STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	**106 CAMERON STREET LAKE WACCAMAW, NC 28450**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		7/27/24

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

Electronically Signed | 07/26/2024

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to provide annual education for the emergency training program to the staff and failed to test the emergency plan in a full-scale community-based exercise at least annually. Findings include: On the facility's 2024 Annual Education Calendar, the Emergency Preparedness (EP) training was annually scheduled in the month of March. A review of the facility's Emergency Preparedness plan was conducted on 6/14/2024 revealed the following: a. There was no documentation regarding annual education of the EP plan to all their staff or providers. b. There was no documentation of an annual full scale community-based exercises was conducted for EP testing. In a phone interview on 7/1/2024 at 1:23 pm with Medication Aide #5, who had worked at the facility 3 years, did not know what the Emergency Preparedness Plan was when asked. When explained it was a plan how staff would respond to emergency events such as fire emergencies or	E 001	The facility has a comprehensive Emergency Program (EP) plan that ensures documentation of education and trainings as of 7/27/2024. On 6/28/2024 the facility conducted a full-scale community-based fire drill exercise for EP plan testing with the local fire department. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. On 7/18/2024, the Licensed Nursing Home Administrator (LNHA) educated the Maintenance Director on the importance of ensuring annual EP education is provided to all staff. On 7/18/2024, the LNHA educated the Maintenance Director on ensuring documentation is completed regarding all annual EP education that is provided to all staff. On 7/18/2024, the LNHA educated the Maintenance Director on the importance of annual documentation of full-scale community-based exercises being conducted for EP plan testing. The LNHA, Maintenance Director, or	

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E 001	Continued From page 2 evacuation of the residents from the facility, she stated the facility had conducted monthly fire drills and she was not aware of the facility evacuation plan in the event of a disaster. She stated she could not recall receiving training on the facility's policies and procedures for Emergency Preparedness in the last year and had not received an educational competency checklist for the last year to complete related to the EP plan. In an interview with Maintenance Director (for the last 6 years) with the Administrator present on 6/14/2024 at 5:00 pm, he stated he had conducted fire drills and an elopement drill with the staff scheduled to work in May 2024 and had not conducted EP training of the EP policies and procedures for all of the staff. He further stated the facility had not conducted a full scale community-based training since the last recertification survey in April 2023. In an interview with the Administrator on 6/14/2024 at 5:00 pm, she explained since the resignation one month ago of Nurse #22, who had worked at the facility for the last six years and was the person responsible for EP training and updating the EP manual, she (the Administrator) was the responsible person of the EP manual. She stated the facility had not participated in a full scale community-based EP training, and since she was unable to locate documentation of EP educational training to all the staff, she could not say all staff had received EP training in the last year on EP policies and procedures. An attempt to reach Nurse #22 was unsuccessful. At the end of the survey on 7/2/2024, the facility did not provide any EP educational training	E 001	Designee will educate all staff on the EP plan by 8/5/2024. After 8/5/2024, newly hired staff will be educated on the EP plan by the LNHA, Maintenance Director, or Designee during their new hire employee orientation. Beginning 7/27/2024, weekly for 12 weeks, the LNHA, Maintenance Director, or Designee will interview 3 staff members across various shifts to validate their knowledge of the EP plan. Beginning 7/27/2024, once (1) a month (at minimum) for 12 months the LNHA, Maintenance Director, or Designee will ensure annual EP education is provided to all staff and the education conducted will be documented regarding the EP plan. Beginning 7/27/2024, the LNHA, Maintenance Director, or Designee will ensure annual full-scale community-based exercises are conducted for EP plan testing and the exercises conducted will be documented regarding the EP plan. The audits will be reviewed by the LNHA, Maintenance Director, or Designee, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the	

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E 001	Continued From page 3 records that had been conducted since the last recertification survey on April 2023.	E 001	audits will continue for the specified timeframe as described in this corrective action.	
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted onsite from 06/10/24 through 06/14/24. Onsite validation of the immediate jeopardy removal plans was conducted on 6/19/24. Addtional information was obtained remotely on 6/26/24 through 7/2/24. Therefore, the exit date was changed to 7/2/24. Event ID# N0PP11. The following intakes were investigated: NC00213318, NC00214039, NC00214303, NC00215202, NC00215973, NC00216122, NC00216128, NC00216401, NC00216423, NC00216522, NC00216980, NC00217469, NC00217555, NC00217685, NC00218316, NC00218317, NC00218320, and NC00218322. 42 of the 78 complaint allegations resulted in deficiencies. Intakes NC00217685, NC00215202, NC00216423, NC00216401, NC00218316, NC00218317, NC00218320, and NC00218322 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of (K) CFR 483.12 at tag F600 at a scope and severity of (K) CFR 483.25 at tag F697 at a scope and severity of (K) CFR 483.45 at tag F755 at a scope and severity	F 000		

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F 000	Continued From page 4 of (K) CFR 483.45 at tag F760 at a scope and severity of (K) The tags F600, F697, and F760 constituted Substandard Quality of Care. Immediate Jeopardy began for F580, F697, and F755 on 5/9/24 and was removed on 6/16/24. Immediate Jeopardy began for F600 on 3/14/24 and was removed on 6/16/24. Immediate Jeopardy began for F760 on 3/14/24 and was removed on 6/15/24. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		7/27/24

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F 550	Continued From page 5 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to treat a resident (Resident #50) with dignity and respect when a nurse refused to leave the resident's room upon request and when the resident was not assisted out of the shower when requested. The resident expressed feelings of anger and frustration. This was for 1 of 1 resident reviewed for dignity. Findings included: Resident #50 was admitted to the facility on 10/06/23. Diagnoses included, in part, right below the knee amputation with prothesis. The Minimum Data Set (MDS) quarterly assessment dated 02/20/24 revealed resident was cognitively intact and demonstrated no	F 550	Resident Rights were violated for resident #50 when nurse #12 did not exit the room when asked to do so. On 6/12/2024, nurse #12 was terminated. The resident voiced satisfaction with the intervention. No negative outcome occurred. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) met with the Regional Ombudsman on 7/11/2024 to schedule a Resident Rights education and presentation to be given by the Regional	

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F 550	Continued From page 6 behaviors. 1a. Review of an investigation report submitted to the Department of Health and Human Services (DHHS) on 02/21/24 for an abuse allegation on 02/15/24 indicated Resident #50 reported that the nurse on night shift (Nurse #12) "hit" his leg three times and was verbally aggressive towards him while attempting to give him his medication. No physical or mental injury was reported. This was reported to the Police and Department of Social Services (DSS) on 02/15/24. Review of the police report dated 02/15/24 stated, "Victim [Resident #50] stated that the offender [Nurse #12] struck him on the leg 3 times and then became verbally aggressive towards him. He did state that he got verbally aggressive with her after the fact. Offender stated that she shook the leg of resident to wake him up for his medications but did not strike him. No injuries were noted at time of reporting." A summary of the facility investigation dated 02/21/24 revealed "Concerns were reported to the Social Worker by the resident [Resident #50]. It was determined that the allegation of physical abuse was unsubstantiated, however it was determined that the employee [Nurse #12] placed her hands on the resident [Resident #50] shaking him when asking if he would take his medications. It was determined the employee [Nurse #12] was verbally aggressive to the resident and provoked him before exiting room. Employee [Nurse #12] admitted to not leaving his room when asked and continued to provoke him." An interview with Resident #50 was conducted on 06/10/24 at 1:00 PM. Resident #50 stated Nurse	F 550	Ombudsman. The Regional Ombudsman completed this education in-person on 7/25/2024 for all staff. Any staff who were not in attendance will be educated by the LNHA, DON, or Designee by 8/5/2024. After 8/5/2024 newly hired staff will be educated on Residents Rights by the LNHA, DON, or Designee during their new hire employee orientation. The LNHA, DON, or Designee, will educate all staff by 8/5/2024 on Resident Rights, Dignity, and Respect. Beginning 7/27/2024, the LNHA, DON, Social Worker, or Designee will conduct an interview with 3 alert and oriented residents per week x 12 weeks to ensure Resident Rights are being followed by all staff members. The questions asked may include but are not limited to asking if staff members enter/leave the resident's room when asked. If a resident has a concern the Social Worker or Designee will write a grievance regarding the concern, investigate the concern, and implement an intervention to rectify the grievance. The LNHA, DON, or Designee will ensure if a staff member is involved in the concern the staff member will be re-educated and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI	

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F 550	Continued From page 7 #12 had come into his room on 02/15/24 at about 9:30 PM, had hit his leg and woke him and told him he needed to take his medications. Resident #50 told Nurse #12 to get out of his room and she hit his leg again, insisting she needed a yes or no answer if he was going to take his medications. Resident #50 stated he again told Nurse #12 to get out of his room and she hit his leg a third time and insisted again that she needed a yes or no answer if he was going to take his medications. Resident #50 stated he told her to get out and he covered his head with the bed covers. He stated he pressed the call light to get another staff member to come in and witness Nurse #12 hitting him and refusing to leave the room. He stated Nurse Aide (NA) #7 came into the room and was trying to get Nurse #12 to leave him alone, but she kept insisting on a yes or no answer. Resident #50 stated he did not give her a yes or no answer, but by him stating "get out" several times, Nurse #12 should have taken that as a refusal to take his medications. He stated he was very upset that Nurse #12 had woken him up to take his medications and he got increasingly angry when she was refusing to leave when he asked her to leave several times. Resident #50 stated he felt like Nurse #12 was treating him like a child. A phone interview with Nurse Aide #7 on 06/27/24 at 12:35 PM revealed on 02/15/24 she was standing at the nurse's station on the 100 hall and she had heard Nurse #12 arguing with Resident #50 and heard Resident #50 saying "get out, get out, get out of my room." NA #7 stated she told NA #6 they needed to go down to his room and see what was going on. NA #7 stated she was standing at Resident #50's room and heard Resident #50 say "I told you to leave my room,"	F 550	Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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and Nurse #12 replied "I am not going anywhere until you say yes or no." NA #7 stated Resident #50 continued to tell Nurse #12 to leave, and Nurse #12 continued to demand a yes or no answer. She stated Resident #50 had the covers over his head and she heard Nurse #12 say "I am going to ask one more time and he said I told you to leave the room." NA #7 stated when she entered the room she tried to encourage Resident #50 to take his medications. She stated the refusal to leave the room as Resident #50 requested and the insistence of taking the medications went on for about 10 minutes. She stated she never saw Nurse #12 strike Resident #50. She added, Nurse #12 had a cup of water in one hand and the medication cup in another hand. NA #7 stated Resident #50 was angry and he was getting louder with Nurse #12 when she kept refusing to leave the room. NA #7 stated there was a lot of name calling between Nurse #12 and Resident #50 with each of them calling each other names such as crazy, liar and stupid.

An interview with NA #6 on 06/19/25 revealed on 02/15/24 Nurse #12 went to Resident #50's room to give him his medications. She stated she could hear Nurse #12 and Resident #50 yelling at the nurse's station which was about 4 rooms away from the nursing station. She stated she could hear Resident #50 telling Nurse #12 to get out of the room and Nurse #12 saying "Yes or no are you going to take your medications?" NA #6 stated the back and forth arguing between Resident #50 and Nurse #12 went on for a few minutes. She and NA #7 went down to the room and she noticed Nurse #12 had a cup of water in one hand and the medication cup in the other hand. NA #6 stated she did not see Nurse #12 physically touch Resident #50, but she was

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refusing to leave the room when he asked her to and Resident #50 was getting angry and upset with Nurse #12 for not leaving when asked to.

A phone interview was conducted with Nurse #12 on 06/14/24 at 4:27 PM. Nurse #12 stated on 02/15/24 she was trying to give Resident #50 his medications and he told me to leave. Nurse #12 stated he did not outwardly refuse, he just kept telling her to get out of his room. Nurse #12 stated the last time Resident #50 refused his medication he accused her of not giving him his medications when he actually refused to take them. She added, she wanted a yes or no answer to accurately document that he refused the medications. Nurse #12 stated she woke him up "gingerly" by shaking his leg one time and she did not touch him more than once. She stated he had the sheet over his head and was telling her to get out of his room. She stated he was upset when she arrived in the room and he did not change his demeanor while she was in the room, but he was yelling at her while she persisted for a yes or no answer and calling her a liar. She stated, in looking back, she should have left the room and accepted him stating "get out of my room" as a refusal and documented that instead of "yes" or "no", but she was concerned he was going to report her to management stating she did not bring in his medications. Nurse #12 denied calling Resident #50 stupid or crazy.

An interview was conducted with the Administrator on 06/14/24 at 5:00 PM. The Administrator stated after she conducted the investigation it had been determined that Nurse #12 did not physically abuse Resident #50 but she did refuse to leave his room when asked several times and failed to treat the resident with

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dignity and respect by honoring his request. The Administrator added, she had three in services regarding dignity and respect since she started in early February 2024. The facility provided a plan of correction for this incident but it was not accepted as it did contain all the required components.

1b. Review of an incident report dated 05/17/24 revealed the resident [Resident #50] reported he asked to get a shower early because his family was visiting. Nurse Aide [NA #8] from another hall took resident to shower and then left. Resident stated he was left in shower room for 15 - 20 minutes before the same Nurse Aide [NA #8] came in and assisted him back to his wheelchair. Camera footage was reviewed and confirmed the call light sounded and was on for 15 minutes and 23 seconds before Nurse Aide [NA #8] came back to the shower to assist Resident in getting back into his wheelchair.

Review of the camera footage time line on an incident report dated 05/17/24 revealed the following:

10:42 AM Resident #50 entered the shower room and NA #8 followed Resident #50 and entered the shower room
10:46 AM Nurse Aide #8 exited the shower room
10:48 AM Nurse Aide #8 reentered the shower room
10:49 AM Nurse Aide #8 exited the shower room
11:00 AM Call light in shower room sounds
11:16 AM Nurse Aide #8 entered the shower room
11:20 AM Nurse Aide #8 and Resident #50 exited shower room and went to Nurse #9 and were telling her something

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An interview with Resident #50 on 06/14/24 at 1:00 PM revealed on 05/17/24, he was left unattended in the shower for over 15 minutes. He stated prior to the shower he was on the smoking porch and stated he wanted to get a shower early on this day because he had family coming. Resident #50 stated Nurse Aide (NA) #8 said he was not on her assignment, but that she would get him started in the shower. He used the call bell to alert for help when he was done. He stated no one came after a few minutes so he turned the water again to keep himself warm and washed himself again while waiting for someone to answer the call bell. He stated he then started to yell for someone to come and help him, but no one came. Resident #50 stated the shower chair did not have wheels like his wheelchair so he was not able to move it easily, but he was able to reach a towel and dry off and reached his prosthetic leg and put it on. He stated he continued to yell, but still no one came. Resident #50 stated he then attempted to transfer himself from the shower chair to the wheelchair but he banged his leg and was not able to transfer himself safely. Resident #50 stated after about 15 minutes, NA #8 finally came back and helped him get out of the shower chair and transferred him to his wheelchair. Resident #50 stated he was very angry and frustrated that he was left unattended and had wait so long to get assistance.

An interview was conducted with NA #8 on 06/14/24 at 2:35 PM. NA #8 reported on 05/17/24 she was on the smoking porch with Resident #50 and he reported he wanted a shower. He stated his aides from the 100 hall were busy so she told him she would get him in the shower. NA #8

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stated she was assigned to the 200 hall, but she helped transfer Resident #50 to a shower chair from his wheelchair and assisted with removing his clothes and his prosthetic leg. She then turned on the water and he began to take his shower. NA #8 stated that she and Nurse #7 who was assigned to the 200 hall told Nurse #9 who was assigned to the 100 hall that they were going to the store to get soap which was located across the street and only minutes away. NA #8 stated they were back within 15 minutes or less and when they came back, they saw the shower light going off and Nurse #9 was sitting at the computer at the nurse's station. She stated she went into the shower room and saw Resident #50 was still in the shower. She assisted him with getting dressed and brought him out of the shower room. She stated Resident #50 was very angry and wanted to know why his aides left him in the shower room.

An interview was conducted with Nurse #7 on 06/13/24 at 11:45 AM. Nurse #7 reported on 05/17/24, Resident #50 was out on the smoking porch and stated he had family coming in to see him today and he wanted a shower and NA #8 said she would give him one. NA #8 assisted Resident #50 in the shower. She stated after he was in the shower, she and NA #8 told Nurse #9 that we were leaving the facility to go to the store across the street to get soap and that Resident #50 was in the shower and for her to let his aides know so they could get him out. Nurse #7 reported they were at store for about 15 minutes and when they came back, the call light was on to the shower room. Nurse #7 stated NA #8 went to the shower room to assist Resident #50 out of the shower. Nurse #7 reported when Resident #50 came out of the shower room, he was very upset

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because no one came to answer his light and assist him.

An interview was conducted with Nurse #9 via phone on 06/13/24 at 2:19 PM. Nurse #9 reported she was the nurse assigned to the 100 hall on 05/17/24 where Resident #50 resided. She stated she was sitting at the nurse's station on 05/17/24 when Resident #50 came to the desk and asked where his aides were. She stated Resident #50 was very upset and frustrated about being left in the shower room and that no one was answering the call light to assist him. She stated Resident #50 told her that NA #8 had put him in the shower and left. Nurse #9 stated she had learned from NA #8 that she and Nurse #7 left the building to go to the store, but it was not until they returned. Nurse #9 stated neither NA #8 nor Nurse #7 reported to her that Resident #50 was in the shower or that they were going to the store. Nurse #9 stated she did not recall hearing the call light going off.

An interview was conducted with NA #4 via phone on 06/18/24 at 10:39 AM. NA #4 reported she had worked at the facility as agency nurse aide for about 8 weeks. She stated she was assigned to Resident #50 on the 100 hall on 05/17/24. NA #4 reported she did not know what had actually happened on 05/17/24 but was told someone put Resident #50 in the shower, but they did not inform her or NA #5 who was also assigned to Resident #50. NA #4 reported Resident #50 and Nurse #9 approached her and NA #5 while they were doing resident care for another resident and Resident #50 was yelling at them for leaving him in the shower, but they had no idea he was even in the shower.

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F 550	Continued From page 14 An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 11:00 AM. The DON reported that a nursing staff member should always be with a resident whenever they were getting a shower. The DON stated she did not know NA #8 and Nurse #7 left the building on 05/17/24 and it was not okay for them to leave without telling anyone. She stated her expectation of nursing staff was that the call bell in shower room should have been responded to when it was sounding. She stated Resident #50 needed assistance with getting dressed and having to wait in a shower room for 15 minutes unassisted and undressed was too long.	F 550		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		7/27/24

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F 580	Continued From page 15 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, and Physician interviews, the facility failed to notify the physician that the scheduled medication gabapentin, a medication ordered for nerve pain that is not to be stopped abruptly, was not administered. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24 and had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being	F 580	The facility failed to notify the physician that the scheduled medication gabapentin was not administered. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. Resident #51 missed a total of 21 doses of the medication from 5/8/2024 through 5/13/2024 and had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain	

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F 580	Continued From page 16 the worst pain possible), numbness in her legs, and spasms and the physician was not notified of this. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The physician was not notified that Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, the facility failed to notify the physician that 14 doses of the antibiotic Amoxicillin 875 mg was administered to Resident #39 instead of the antibiotic Augmentin (Amoxicillin-Clavulanate 875 mg-125 mg) that was ordered by the physician on discharge from the hospital. This deficient practice affected 3 of 10 residents reviewed for notification. Immediate Jeopardy began for Resident #51 on 5/9/24 when the resident reported a pain scale of 10, had not been receiving gabapentin, and the physician was not notified, and on 5/12/24 for Resident #46 when the resident had increased pain, difficulty sleeping, had not been receiving gabapentin, and the physician was notified. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Example #3 was cited at scope and severity "D." Findings included: 1. Resident #51 was admitted on 10/19/23 with diagnosis which included in part: chronic pain	F 580	possible), numbness in her legs, and spasms and the physician was not notified of this. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The physician was not notified that Resident #46 missed 14 doses of the medication from 5/10/2024 through 5/17/2024 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, the facility failed to notify the physician that 14 doses of the antibiotic Amoxicillin 875 mg was administered to Resident #39 instead of the antibiotic Augmentin (Amoxicillin-Clavulanate 875 mg-125 mg) that was ordered by the physician on discharge from the hospital. This deficient practice affected 3 of 10 residents reviewed for notification. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Immediate Jeopardy began for Resident #51 on 5/9/2024 when the resident reported a pain scale of 10, had not been receiving gabapentin, and the physician was not notified, and on 5/12/2024 for Resident #46 when the resident had increased pain, difficulty sleeping, had not been receiving gabapentin, and the physician was notified. Upon identification of the severity of the	

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F 580	Continued From page 17 syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities). Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. The May 2024 Medication Administration Record (MAR) indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. This MAR and the medication administration notes revealed Resident #51's gabapentin was not administered on 5/8/24 at 5:00 PM and 9:00 PM and on 5/9/24, 5/10/24, 5/11/24, 5/12/24 and 5/13/24 at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. A pain assessment dated 5/9/24 was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse #9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse #9 stated Resident #51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse #9 indicated Resident #51 refused her shower on	F 580	alleged deficient practices, the Licensed Nursing Home Administrator (LNHA) wrote the Immediate Jeopardy Removal Plan and submitted the Removal Plan for approval. The Immediate Jeopardy was removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The LNHA terminated the agency Director of Nursing (DON) during extended survey on 6/19/2024. The LNHA hired an experienced non-contractual DON on 6/19/2024 to ensure future compliance. The facility has also hired nursing staff including RNs and LPNs to ensure future compliance. The DON or Designee will review all Medication Administration Records (MARs) from March 2024 to July 2024 for residents receiving pain medications, as well as antibiotics, to ensure there are no missing doses. All missing doses will be reported to the provider and documentation will follow to ensure compliance by 8/5/2024. The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the steps to follow when a medication is not in stock, as well as proper documentation that describes all steps that were taken to ensure the resident receives their medications as ordered to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation.	

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F 580	Continued From page 18 5/9/24 which was not normal for her, reporting she was in too much pain. Nurse #9 stated she was not aware that she should have notified the physician of Resident #51's increased pain and the ordered medication gabapentin that was not administered. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 indicated she did not notify the physician that Resident #51 had not received the scheduled gabapentin. Nurse #8 stated she did not realize that she should have notified the physician that the medication was not available and not administered as ordered. Nurse #8 stated she did not report Resident #51's increased pain to the physician. A nursing progress note by Nurse #13 on 5/10/24 at 3:24 AM stated Resident #51 reported her legs were numb. The note stated the nurse informed Resident #51 there were no interventions for that and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room. Attempts were made to interview Nurse #13 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication	F 580	Beginning 7/27/2024, the DON or Designee will audit pain medication administrations 5 times per week for 12 weeks to ensure all pain medications are given as ordered. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the DON or Designee will audit all antibiotic medication administrations 5 times per week for 12 weeks to ensure there are no missing doses. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not notify the physician that the medication gabapentin was not available and not administered and had increased pain. Unit Manager #1 was unable to explain why she did not notify the physician that the ordered medication gabapentin was not administered to Resident #51.

A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to emergency room. Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal.

An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated due to acute pain and received gabapentin. The discharge instructions were to take prescription medications as ordered including gabapentin 800 mg 4 times per day and to not stop taking prescription medication for pain suddenly.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM and was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain.

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Nurse #2 stated she notified the provider of the resident's change in condition and requested to be sent to the hospital. Resident #51 was sent to the hospital per her request.

Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. Nurse #14 worked at the facility through an agency.

A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening "muscle spasms all over" and requested to go to the emergency department. 911 was called for transfer to the emergency room. Resident #51 returned to the facility having received Gabapentin at the emergency room. Resident #51 told the emergency room staff that until she received her Gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. Emergency room physician sent a new prescription for Gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM.

An ED Summary dated 5/13/24 indicated Resident #51 was evaluated due to acute pain. Resident #51 received gabapentin in the emergency room and the emergency room physician sent a new prescription for gabapentin to the pharmacy.

An in-person interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for

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Resident #51 and why the physician was not notified. The DON stated she expected the nurses to notify the physician when medications were not available for administration.

An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications would be available and administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identify that a medication was not available for administration.

An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated she was in the position at the facility since 6/7/24. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered and if the ordered medication was not obtained the physician should be notified.

Attempts were made via phone to interview the previous physician with messages left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received.

2. Resident #46 was admitted on 12/6/23 with diagnosis which included diabetes and

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neuropathy.

Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain.

Resident #46's May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM. The MAR revealed on 5/10/24 at 9:00 PM, and on 5/11/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24, 5/16/24 and 5/17/24 at 9:00 AM and 9:00 PM, the nursing staff documented the gabapentin was not administered.

An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin the medication was not administered due to it being unavailable. Nurse #3 stated she did not notify the physician that she had not administered the prescribed medication gabapentin and was unaware that she should have done this.

An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that worked at the facility for several months. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart and she did not notify the physician that the gabapentin was not

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administered. Nurse #6 stated she was not aware that she was supposed to notify the physician.

An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse #17 indicated she was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24 from 7:00 PM to 7:00 AM. Nurse #17 stated she did not notify the physician that she did not administer the scheduled gabapentin on 5/13/24, 5/14/24 and 5/15/24. Nurse #17 did not have an explanation why she did not notify the physician.

An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 recalled gabapentin was not available on the medication cart, but she did not notify the physician. Nurse #7 stated Resident #46 was upset and had increased pain when she did not receive the ordered gabapentin. Nurse #7 was unable to explain why she had not notified the physician of Resident #46's medication gabapentin not administered and resident's increased pain.

An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered, resident

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had increased pain and she did not notify the physician.

An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM. Nurse #5 stated she did not notify the physician the medication was unavailable or of the missed doses.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the prescribed dose for Resident #46 on 5/17/24 and she did not notify the physician.

Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM. Messages were left on 6/11/24 and 6/12/24 with no return call received.

An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated she had gone without gabapentin for days at a time on several occasions. Resident #46 reported staff stated the medication was coming from the pharmacy and then it didn't come in. Resident indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not receive her gabapentin. Resident #46 stated it was horrible and the staff told her she would just

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have to wait it out until the medication came in. Resident #46 stated she was not aware if the physician was notified of her medication not being administered as ordered.

An in-person interview with the Director of Nursing (DON) on 6/12/24 at 4:15 PM revealed the nurses on the medication cart were expected to notify the physician when a medication was not available and administered as ordered. The DON stated she started at the facility at the end of March 2024. The DON stated she was not aware the physician was not notified. The DON expected the nurses to notify the physician of changes in condition including uncontrolled pain, medications not administered, and residents transferred to the hospital for evaluation.

An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected the physician to be notified when medications were not available and administered as ordered. The Administrator stated nursing staff did not understand what to do when they identified a medication was not available for administration and this included notification of the physician for further orders.

An interview was conducted by phone with the Physician on 6/18/24 at 1:20 PM. The Physician stated she had been in the position since 6/7/24. The Physician indicated the dose of gabapentin ordered, 800 mg twice per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the risk of withdrawal and increased pain. Withdrawal symptoms can occur within 12 hours and can be severe. The Physician stated increased pain was

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a definite concern due to not receiving the scheduled gabapentin as ordered. She stated it was the responsibility of the facility to notify the physician when a scheduled medication was not available.

Attempts were made via phone to interview the previous physician with messages left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received.

The Administrator was notified of Immediate Jeopardy on 6/13/24 at 2:15 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

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

The facility failed to notify the provider when two residents (Resident #51 and Resident #46) were not administered their ordered gabapentin for multiple doses.

Resident #51 was not administered her routine order for gabapentin 800 mg 4 times a day from 05/08/2024 - 05/13/2024. A licensed nurse stated she did not notify the physician when the medication was not available. The nurse stated that if medication was not available for a few days, then she would call the pharmacy. The facility Unit Manager #1 was aware of the gabapentin not being available but did not recall what happened or what she did about obtaining the medication. The documentation in the electronic health record (EHR) showed no evidence that the physician was notified.

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On 05/09/2024 Resident #51 refused a shower due to too much pain. On 05/10/2024 Resident #51 complained of her legs feeling numb. On 05/12/2024 Resident #51 complained of pain and spasming in which Resident #51 requested to go to the Emergency Room (ER). Resident #51 returned from the ER where the resident was treated for acute pain and received gabapentin at the hospital. In the evening on 05/12/2024 Resident #51 complained of agitation and anxiety due to not receiving gabapentin and requested to go to the ER. Resident #51 received gabapentin in the ER. The physician in the ER sent a new prescription for gabapentin to the pharmacy.

Resident #46 was not administered her routine order for gabapentin 800 mg 2 times a day from 05/10/2024 - 05/17/2024. Unit Manager #2 stated there had been delays in receiving refills of gabapentin and resident had been without the ordered gabapentin. She stated she did not notify the physician.
Resident #46 had a pain level of 8 or 9 constantly during the time the facility failed to obtain and administer the medication. Resident #46 complained of not receiving pain medication which caused her more pain and made it hard to sleep. Resident #46 complained of irritability, being anxious, and nausea. Resident #46 had not felt well and had not been able to get out of bed to participate in activities and perform a daily routine due to pain in her legs.

Residents with missed medications, changes in conditions, and residents who have had a documented risk management report are at a greater risk of the physician not being notified. Therefore, effective 06/13/2024, the

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Administrator, Director of Nursing, and Unit Managers (UMs) completed an audit for the past 90 days of all residents in the facility who had missed medications, changes in conditions, and/or a documented risk management report to ensure the physician had been notified. On 06/15/2024 it was determined by this audit that the physician had not been notified of every missed medication, change in condition, and documented risk management report. The concerns were identified and reported to the physician to ensure the notification of change. A documented risk management report is a report that a nurse completes to document resident incidents such as medication errors, falls, skin tears, pressure ulcers, etc. Any resident incident that occurs in the facility is documented in the electronic health record. It includes general details of the incident, a description of the incident, any statements from the resident or witnesses and any follow-up action to be taken by the nursing staff.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete:

On 06/13/2024 the Director of Nursing educated Floor Nurses and Unit Managers (UMs) on the process to notify the physician when there are missed medications, changes in conditions, and/or a resident who has a documented risk management report. Nurses will notify the physician immediately via phone call to the on-call service provider that is posted at each nursing station. This process will happen if the nurse is working in the facility and witnesses a missed medication, change in condition, and/or if

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the nurse completes a documented risk management report on any resident. The Director of Nursing and Unit Managers (UMs) will begin in person education on 06/13/2024 with all nurses and medication aides which will include all full-time, part-time, as needed, and agency staff. This education will be on the importance of notifying the physician of any missed medications, changes in conditions, and documented risk management reports.

No nurses or medication aides will work after 06/13/2024 until they have received the above noted education. The Director of Nursing will be responsible for keeping up with those nurses and medication aides who have and have not been educated. The Director of Nursing is responsible for completing the education or assigning the UM to complete the education for any staff who has not been educated by 06/13/2024. The UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure staff notify the provider when there are missed medications, changes in conditions, and/or if a resident has a documented risk management report. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

On 06/14/2024 the Director of Nursing and provider reviewed the facility provider communication log. Effective 06/13/2024 the Director of Nursing will provide education to ensure all nurses and medication aides (full-time, part-time, as needed, and agency) have comprehensive knowledge of how to utilize the provider communication log. The provider

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communication log is located in a white binder at each nursing station in the facility. The Floor Nurses and UMs will utilize this provider communication log daily to document any reason for why the provider should see a resident such as for a sick visit, readmission, new admission, orders to be signed, at the resident's request, at the resident's families request, medication refills, changes in conditions, and/or documented risk management reports. Effective as of 06/13/2024 Floor Nurses and UMs will be responsible for ensuring this provider communication log is updated daily. The Floor Nurses and UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure staff notify the provider when there are missed medications, changes in conditions, and/or a resident who has a documented risk management report. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

All newly hired nurses and medication aides, (full-time, part-time, as needed, and agency) will be educated as noted above. This will be completed by the Director of Nursing. The Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Director of Nursing is responsible for completing the education with new hires. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

Alleged date of immediate jeopardy removal: 6/16/24

The removal plan of the Immediate Jeopardy was

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validated on 06/19/24. The audit conducted for all residents who had missed medications, changes in conditions, and/or a documented risk management report to ensure the physician had been notified was verified and confirmed any identified concerns were reported to the physician. A sample of staff including the Administrator, Unit Manager, nurses and medication aides were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding the process of notifying the physician when there are missed medications or changes in condition. The IJ removal date of 06/16/24 was validated.

3. Resident #39 was admitted to the facility on 05/02/24 with a diagnosis of a urinary tract infection (UTI).

The hospital discharge summary dated 05/02/24 revealed the following physician order: Amoxicillin-Clavulanate 875 mg-125 mg tablet oral every 12 hours for 7 days, (Augmentin). Amoxicillin-Clavulanate is a combination penicillin-type antibiotic used to treat a wide variety of bacterial infections.

The facility MAR (Medication Administration Record) for May 2024 revealed Resident #39 was administered Amoxicillin 875 mg-give 1 tablet by mouth every 12 hours for a UTI x 7 days. He received the Amoxicillin 875 mg on the following dates for a total of 14 doses: 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/07/24, 05/08/24, 05/09/24, and 05/10/24.

Review of an admission Minimum Data Set (MDS) assessment dated 05/08/24 revealed

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Resident #39 had intact cognition. He had an indwelling urinary catheter. He had undergone recent genitourinary surgery (refers to the urinary organs of the body) that required skilled nursing care. He was administered antibiotic medication.

Review of the Consultant Pharmacist ' s Medication Regimen Review dated 05/27/24 revealed the following recommendation: "This resident was admitted with an order for Amoxicillin/Clavulanate 875 MG BID (twice a day) for 7 days. This was entered into the computer as Amoxicillin 875 MG. This is what the pharmacy sent. Please notify the provider of the medication error to clarify if any additional treatment is needed. Please review with the nurses to ensure they read orders carefully and double check entries."

In an interview with the Consultant Pharmacist on 6/12/24 at 9:50 AM she stated the difference between Amoxicillin and Amoxicillin-Clavulanate was that the Clavulanate drug helped the Amoxicillin work better and more types of bacteria were affected by the addition of Clavulanate. She would have expected the provider to be notified to report the medication error and determine if additional treatment was necessary.

In an interview with the Director of Nursing (DON) on 06/12/24 at 4:40 PM she stated she had not followed up on the pharmacy recommendation and had not notified the provider that the wrong antibiotic had been administered to Resident #39 to determine if further treatment was necessary.

In an interview with the facility physician on 06/19/24 at 9:30 AM she stated she had not been notified that Resident #39 was given the wrong

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F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, Psychiatrist, Physician, and Wound Clinic Physician, the facility failed to protect the residents' right to be free of neglect when the facility failed to obtain significant medications (Resident #51, Resident #46, and Resident #8), administer significant	F 600	The facility failed to protect the residents' right to be free of neglect when the facility failed to obtain significant medications, administer significant medications, notify the physician that scheduled medication for nerve pain that was not to be stopped abruptly was not administered, and provide effective pain management.	7/27/24

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F 600	Continued From page 34 medications (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8), notify the physician that scheduled medication for nerve pain that was not to be stopped abruptly was not administered (Resident #51 and Resident #46), and provide effective pain management (Resident #51 and Resident #46). Resident #269 was administered 6 doses of haloperidol (antipsychotic medication) 20 milligrams (mg) instead of the ordered dosage of 2 tablets of 2 mg at bedtime and was not administered carvedilol (a medication used to treat heart failure, high blood pressure and chest pain) for 25 of the ordered doses. Resident #269 experienced an elevated pulse and shortness of breath requiring Emergency Department (ED) evaluation on 3/14/24. Resident #51's scheduled gabapentin was not obtained and administered for 21 doses resulting in ineffective pain management as evidenced by complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. The physician was not notified. Resident #51 was transferred to the ED twice on 5/12/24 where she was treated for acute pain with gabapentin and returned to the facility. Resident #46's scheduled gabapentin was not obtained and administered for 14 doses resulting in ineffective pain management as evidenced by increased pain, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. The physician was not notified. Resident #419 was not administered 6 doses of intravenous (IV) (delivered into the vein) Rocephin (antibiotic) and 7 doses of IV Daptomycin (antibiotic) for treatment of his infected stage 4 sacral (triangular bone at the	F 600	The facility failed to protect Residents #46, #51, #269, and #419 from neglect as evidenced by the following deficient practices: F580: The facility failed to notify the physician when two residents (Resident #51 and #46) were not administered their ordered gabapentin for multiple doses. F697: The facility failed to effectively manage Resident #51's and Resident #46's pain. F755: The facility failed to ensure routine pain medication was obtained and available for administration for Resident #51 and Resident #46. F760: The facility failed to prevent significant medication errors for Resident #269, Resident #419, Resident #51, and Resident #46. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Immediate Jeopardy began on 3/14/2024 when the facility neglected to administer Resident #269's haloperidol and carvedilol as ordered and the resident required ED evaluation due to shortness of breath and an elevated pulse. Immediate Jeopardy was removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal.	

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F 600	Continued From page 35 base of the spine) pressure ulcer. The resident was hospitalized and the discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection). This deficient practice affected 9 of 10 residents reviewed for neglect. Immediate Jeopardy began on 3/14/24 when the facility neglected to administer Resident #269's haloperidol and carvedilol as ordered and the resident required ED evaluation due to shortness of breath and an elevated pulse. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Residents #8, #10, #32, #39, and #50 were cited at scope and severity "E". The findings included: This tag is cross referenced to: F580: Based on record review, and staff, resident, and Physician interviews, the facility failed to notify the physician that the scheduled medication gabapentin, a medication ordered for nerve pain that is not to be stopped abruptly, was not administered. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24 and had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being	F 600	Upon identification of the severity of the alleged deficient practices, the Licensed Nursing Home Administrator (LNHA) wrote the Immediate Jeopardy Removal Plan and submitted the Removal Plan for approval. The Immediate Jeopardy was removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The LNHA terminated the agency Director of Nursing (DON) during extended survey on 6/19/2024. The LNHA hired an experienced non-contractual DON on 6/19/2024 to ensure future compliance. The facility has also hired nursing staff including RNs and LPNs to ensure future compliance. The DON or Designee will review all Medication Administration Records (MARs) from March 2024 to July 2024 for residents receiving pain medications to ensure there are no missing doses. All missing doses will be reported to the provider and documentation will follow to ensure compliance by 8/5/2024. The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the steps to follow when a medication is not in stock, as well as proper documentation that describes all the steps that were taken to ensure the resident receives their medications as ordered to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation.	

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F 600	Continued From page 36 the worst pain possible), numbness in her legs, and spasms and the physician was not notified of this. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The physician was not notified that Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, the facility failed to notify the physician that 14 doses of the antibiotic Amoxicillin 875 mg was administered to Resident #39 instead of the antibiotic Augmentin (Amoxicillin-Clavulanate 875 mg-125 mg) that was ordered by the physician on discharge from the hospital. This deficient practice affected 3 of 10 residents reviewed for notification. F697: Based on record review, staff, resident, Consultant Pharmacist, and Physician interview, the facility failed to provide effective pain management and manage symptoms of withdraw for 2 of 10 residents (Resident #51 and Resident #46) reviewed for pain management. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not available to administer and resulted in a total of 21 doses of the prescribed medication not administered from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain at up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) per her request on 5/12/24 in the middle of the night where she was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED	F 600	The DON or Designee will educate all nurses by 8/5/2024 on the importance of completing pain assessments daily for all residents that are receiving pain medications to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit pain medication administrations 5 times per week for 12 weeks to ensure all pain medications are given as ordered. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the DON or Designee will interview 3 residents per week x 12 weeks to ensure his/her pain is being managed effectively. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Any pain that a resident expresses that is not being managed effectively will be reported to the provider. Beginning 7/27/2024, the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to	

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F 600	Continued From page 37 that evening per her request for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not available to administer on 5/10/24 and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in increased pain at a sustained 8-9 pain level, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. F755: Based on record review, staff, resident, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, and Physician interview, the facility failed to ensure scheduled medication was obtained and available for administration for 3 of 10 residents (Resident #51, Resident #46, and Resident #8) reviewed for medications. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) on 5/12/24 in the middle of the night after missing 14 doses of the medication. She was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED that evening for worsening muscle spasms. She was again treated for acute	F 600	assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, Resident #8 was prescribed Oxycodone/Acetaminophen (opioid medication) 10/325 mg and this medication was not obtained from the pharmacy resulting in multiple missed doses of the medication.

F760: Based on record review and interviews with resident, staff, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, Physician, and Wound Clinic Physician, the facility failed to prevent significant medication errors for 9 of 10 residents reviewed (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8). Resident #269 was administered 6 doses of haloperidol (antipsychotic medication) 20 milligrams (mg) instead of the ordered dosage of 2 tablets of 2 mg at bedtime and was not administered carvedilol (a medication used to treat heart failure, high blood pressure and chest pain) for 25 of the ordered doses. Resident #269 experienced an elevated pulse and shortness of breath requiring Emergency Department (ED) evaluation on 3/14/24. Resident #51 was not administered 21 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/8/24 through 5/13/24 resulting in complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being

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the worst pain possible), numbness in her legs, and spasms. She was transferred to the ED twice on 5/12/24 where she was treated for acute pain with gabapentin and returned to the facility. Resident #46 was not administered 14 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/10/24 through 5/17/24 resulting in increased pain, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Resident #419 was not administered 6 doses of intravenous (IV) (delivered into the vein) Rocephin (antibiotic) and 7 doses of IV Daptomycin (antibiotic) for treatment of his infected stage 4 sacral (triangular bone at the base of the spine) pressure ulcer. The resident was hospitalized on 4/5/24 and the 4/26/24 discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection). In addition, the facility: administered 14 doses of Amoxicillin (antibiotic) to Resident #39 instead of the ordered Amoxicillin-Clavulanate; did not administer 34 doses of Resident #32's ordered mirtazapine (antidepressant medication); did not administer 23 doses of Resident #10's ordered tetrabenazine prescribed for the treatment of tardive dyskinesia (involuntary movements such as tongue thrusting, rapid eye blinking, repetitive chewing, that can occur with long term psychotropic use); did not follow the parameters indicated in the physician's order for Resident #50's blood pressure medication resulting in 8 doses not administered as ordered; and did not administer 12 doses of Resident #8's Oxycodone/Acetaminophen (opioid pain medication), 3 doses of Ozempic (anti-diabetic medication), 1 dose of Glipizide (anti-diabetic medication), and 1 dose of

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Rivaroxaban (anticoagulant).

An interview was conducted via phone with the Physician on 6/18/24 at 1:20 pm. The Physician indicated it was the facility's responsibility to provide the services necessary for the residents.

An interview was conducted in person with the Director of Nursing (DON) on 6/14/24 at 4:10 PM. The DON indicated that staff not providing services needed to the resident was a form of neglect. She indicated education was provided to nursing staff to educate them on providing services the residents required.

The Administrator was notified of immediate jeopardy on 6/13/24 at 5:00 PM.

The facility provided the following immediate jeopardy removal plan:

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

The facility failed to protect Residents #46, #51, #269, and #419 from neglect as evidenced by the following deficient practices:

580: The facility failed to notify the physician when two residents (Resident #51 and #46) were not administered their ordered gabapentin for multiple doses.
697: The facility failed to effectively manage Resident #51's and Resident #46's pain.
755: The facility failed to ensure routine pain medication was obtained and available for administration for Resident #51 and Resident #46.

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F 600	Continued From page 41 760: The facility failed to prevent significant medication errors for Resident #269, Resident #419, Resident #51, and Resident #46. The facility became aware of this neglect allegation for Resident #51 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The facility became aware of this neglect allegation for Resident #46 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The facility became aware of this neglect allegation for Resident #269 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The facility became aware of this neglect allegation for Resident #419 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The Administrator and Director of Nursing identified that all current residents have the potential to be affected by this deficient practice. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring	F 600		

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and when the action will be complete:

On 06/13/2024 the Administrator, Director of Nursing, Social Worker, and Unit Managers (UMs) began educating all staff on the facility abuse and neglect policy. This education will be on the importance of staff understanding that all residents have a right to be free of neglect and that failing to provide the necessary care and services to residents constitutes neglect. All staff will have a comprehensive understanding that the following are necessary care and services: obtaining and administering medications as ordered by provider, effectively managing pain, and notifying the physician of significant changes to include any issues with administering significant medications as ordered. The Administrator, Director of Nursing, Social Worker, and Unit Managers (UMs) will begin in person education on 06/13/2024 with all staff which will include all full-time, part-time, as needed, contract staffing departments, and agency staff.

No staff member will work after 06/13/2024 until they have received the education. The Social Worker and Director of Nursing will be responsible for keeping up with staff who have and have not been educated. The Social Worker, the Director of Nursing, and UMs are responsible for completing the education with all staff including any staff who have not been educated by 06/13/2024. The UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Social Worker and the Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure the facility implements effective systems so that residents receive the necessary care and

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services that are needed. The Social Worker and the Director of Nursing were notified of this responsibility on 06/13/2024 by the Administrator.

All newly hired staff (full-time, part-time, as needed, contract staffing departments and agency) will be educated as noted above. This will be completed by the Social Worker, Human Resources Coordinator, and/or Director of Nursing. The Social Worker, Human Resources Coordinator, and the Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Social Worker, Human Resources Coordinator, and the Director of Nursing are responsible for completing the education with new hires. The Social Worker, Human Resources Coordinator, and the Director of Nursing were notified of this responsibility on 06/13/2024 by the Administrator.

Alleged date of immediate jeopardy removal: 6/16/24

The removal plan of the Immediate Jeopardy was validated on 06/19/24. A sample of staff including the Administrator, Unit Manager, nurses and medication aides were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they had been in-serviced regarding the importance of staff understanding that all residents have a right to be free of neglect and understood that failing to provide the necessary care and services to residents constitutes neglect such as obtaining and administering medications as ordered, managing pain, and notifying the physician of significant changes. The IJ removal date of 6/16/24 was validated.

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F 609	Continued From page 44	F 609		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a report of an allegation of neglect to Adult Protective Services (APS) and law enforcement within the required time frame for 4 of 4 residents (Resident #46, #51, #269 and #419) reviewed for neglect. The facility was	F 609	The facility failed to submit a report of an allegation of neglect that was alleged during an annual recertification survey and complaint investigation to Adult Protective Services (APS) and law enforcement within the required time	7/27/24

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F 609	Continued From page 45 officially notified of neglect on 06/13/24 at 2:15 PM when an immediate jeopardy template was issued. The facility did not notify APS or law enforcement within the required time frame following notification. Findings included: Review of the facility provided initial allegation report dated 06/14/24 regarding Residents #46, #51, #269, and #419 revealed no documentation of APS being notified and no record of law enforcement notification. During an annual recertification survey and complaint investigation, the facility was officially notified of neglect on 06/13/24 at 2:15 PM and an immediate jeopardy template was issued to the Administrator. The immediate jeopardy template was signed by the Administrator and the Administrator was verbally informed of the information regarding the situation involving neglect. Review of the state agency records revealed the facility submitted an initial report to the State Agency within the required time frame following the notification of neglect, however documentation supported that the facility did not notify law enforcement or APS until 06/16/24. During a phone interview with the facility Administrator on 06/17/24 at 4:30 PM, she stated she submitted an initial allegation report to the State Agency regarding the neglect information provided on the template which she had received on 06/13/24. She stated since the neglect was identified by the state surveying staff and she received a template for the immediate jeopardy she was confused as to whether or not she would still have to notify APS and law enforcement. She	F 609	frame for 4 of 4 residents (Resident #46, #51, #269 and #419) who were reviewed for neglect. The facility was officially notified of neglect on 6/13/2024 at 2:15 PM when an immediate jeopardy template was issued to the Licensed Nursing Home Administrator (LNHA). Review of the state agency records revealed the facility submitted an initial report to the State Agency within the required time frame following the notification of neglect. However, documentation supported that the facility did not notify APS or law enforcement until 6/16/2024. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA) or Designee will review all facility allegations of abuse by 7/27/2024, since March of 2024, to validate that APS and law enforcement were notified timely. The LNHA or Designee will educate the DON, Social Worker, and other involved staff members by 8/5/2024 on reporting allegations timely and within the required time frame per the regulation. After 8/5/2024 newly hired staff will be educated by the LNHA, DON, or Designee during their new hire employee orientation. Beginning 7/27/2024, the LNHA or	

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	345185	A. BUILDING _____ B. WING _____	C 07/02/2024

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F 609	Continued From page 46 stated it was not until she was reviewing the template and the initial allegation report on 06/16/24 when she realized she should notify law enforcement and APS and on 06/16/24 she notified both.	F 609	Designee will audit all allegations of abuse for 12 weeks to ensure there is timely reporting to APS and law enforcement. If there are any concerns that were not reported to APS or law enforcement, they will be reported immediately, and re-education will be completed. Beginning 7/27/2024, the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified	F 636		7/27/24

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F 636	Continued From page 47	F 636		

by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission,

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F 636	Continued From page 48 excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the comprehensive Minimum Data Set (MDS) assessments within the required timeframe for 5 of 29 residents reviewed for MDS assessments (Resident #269, Resident #17, Resident #9, Resident #24 and Resident #16). Findings included: a. Resident #269 was admitted on 3/7/24. Resident #269's admission Minimum Data Set (MDS) dated 3/14/24 was completed on 5/15/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were	F 636	The facility failed to complete the comprehensive Minimum Data Set (MDS) assessments within the required timeframe for 5 of 29 residents reviewed for MDS assessments (Resident #269, Resident #17, Resident #9, Resident #24 and Resident #16). All comprehensive MDS assessments have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will review the comprehensive MDS assessments for all residents, from March of 2024, to ensure they are all completed timely by 8/5/2024. The DON or Designee will educate the MDS Coordinator and all staff who are responsible for completing sections on the MDS assessment by 8/5/2024 on the regulation related to “Resident Assessment” and on the importance of timely completion of MDS assessments to ensure they are completed in the required timeframe. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee	

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F 636	Continued From page 49 not completed within the regulatory timeframe, and she was looking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner. b. Resident #17 was admitted on 12/29/22. Resident #17's annual Minimum Data Set (MDS) assessment dated 5/1/24 was completed on 6/12/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The	F 636	orientation. Beginning 7/27/2024, the DON or Designee will audit all “In Progress” comprehensive MDS assessments on a weekly basis for 4 weeks (Monday – Friday) to ensure all comprehensive MDS assessments are completed within the required timeframe. Any issues with late submissions of comprehensive MDS assessments will result in re-educating the appropriate staff members and additional training. Beginning 7/27/2024, the DON or Designee will audit all “In Progress” comprehensive MDS assessments monthly for three months. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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DON stated the expectation was that MDS assessments would be completed in a timely manner.

c. Resident #9 was admitted on 12/28/16.

Resident #9's annual Minimum Data Set (MDS) assessment dated 4/26/24 was completed on 6/12/24.

An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind.

An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution.

An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner.

d. Resident #24 was admitted on 5/4/23.

Resident #24's annual Minimum Data Set (MDS)

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assessment dated 5/1/24 was completed on 6/12/24.

An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind.

An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution.

An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner.

e. Resident #16 was readmitted on 5/9/24.

Resident #16's admission Minimum Data Set (MDS) assessment dated 5/15/24 was completed on 5/27/24.

An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training shince she started in May taking online MDS courses to learn the

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F 636	Continued From page 52 requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were beind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was lokking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly assessments within the required 14-day timeframe for 14 of 29 residents reviewed for quarterly MDS assessments. (Resident #20, Resident #36, Resident #51, Resident #22, Resident #38, Resident #61, Resident #63, Resident #5,	F 638	The facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required 14-day timeframe for 14 of 29 residents reviewed for quarterly MDS assessments (Resident #20, Resident #36, Resident #51, Resident #22, Resident #38, Resident #61,	7/27/24

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F 638	Continued From page 53 Resident #21, Resident #47, Resident #7, Resident #14, Resident #26, and Resident #58). Findings included: a. Resident #20 was admitted on 4/8/22. Resident #20's quarterly Minimum Data Set (MDS) assessment dated 5/1/24 was listed as in progress and was incomplete. b. Resident #36 was admitted to the facility on 2/8/24. Resident #36's quarterly Minimum Data Set (MDS) assessment dated 5/15/24 was completed on 6/11/24. c. Resident #51 was admitted on 10/19/23. Resident #51's quarterly Minimum Data Set (MDS) assessment dated 4/4/24 was completed on 6/4/24. d. Resident #22 was admitted on 9/8/17. Resident #22's quarterly Minimum Data Set (MDS) assessment dated 3/29/24 was completed on 5/30/24. e. Resident #38 was admitted on 8/14/20. Resident #38's quarterly Minimum Data Set (MDS) assessment dated 4/22/24 was completed on 6/11/24. f. Resident #61 was admitted on 1/11/24. Resident #61's quarterly Minimum Data Set (MDS) assessment dated 4/18/24 was completed on 6/11/24. g. Resident #63 was admitted on 2/1/24. Resident #63's quarterly Minimum Data Set (MDS) assessment dated 5/3/24 was completed	F 638	Resident #63, Resident #5, Resident #21, Resident #47, Resident #7, Resident #14, Resident #26, and Resident #58). All quarterly MDS assessments have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will review the quarterly assessments for all residents, from March of 2024, to ensure they were all completed timely by 8/5/2024. The DON or Designee will educate the MDS Coordinator and all staff who are responsible for completing sections on the MDS assessment by 8/5/2024 on the importance of timely completion of MDS assessments to ensure they are completed in the required timeframe. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit all quarterly MDS assessments on a weekly basis for 4 weeks (Monday – Friday) to ensure all quarterly MDS assessments are completed within the required timeframe. Any issues with late submissions of quarterly MDS assessments will result in re-educating the appropriate staff members and additional training. Beginning 7/27/2024, the DON or Designee will audit all “In Progress” quarterly MDS assessments monthly for	

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F 638	Continued From page 54 on 6/13/24. h. Resident #5 was admitted on 12/17/20. Resident #5's quarterly Minimum Data Set (MDS) assessment dated 4/15/24 was completed on 6/11/24. i. Resident #21 was admitted on 4/19/21. Resident #21's quarterly Minimum Data Set (MDS) assessment dated 4/8/24 was completed on 6/4/24. j. Resident #47 was admitted on 12/13/21. Resident #47's quarterly Minimum Data Set (MDS) assessment dated 5/3/24 was completed on 6/13/24. k. Resident #7 was admitted on 10/12/10. Resident #7's quarterly Minimum Data Set (MDS) assessment dated 4/8/24 was completed on 6/5/24. l. Resident #14 was admitted on 5/26/16. Resident #14's quarterly Minimum Data Set (MDS) assessment dated 5/2/24 was completed on 6/13/24. m. Resident #26 was admitted on 8/29/23. Resident #26's quarterly Minimum Data Set (MDS) assessment dated 4/11/24 was completed on 6/11/24. n. Resident #58 was admitted on 12/6/23. Resident #58's quarterly Minimum Data Set (MDS) dated 5/24/24 was listed as in progress and was not completed. An interview was conducted on 06/17/24 at 1:37 PM with the Remote MDS Nurse. She stated she	F 638	three months. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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F 638	Continued From page 55 was aware that MDS assessments were not completed within the state designated time frame. The Remote MDS Nurse stated she was contracted on 04/30/24 to complete MDS assessments and the facility was behind on assessments when she started. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she started in May and was training taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed assessments since she started. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview was conducted with the Administrator on 6/11/24 at 1:42 PM. The Administrator stated she had been in the position since February of this year. The Administrator stated there had been changes in the role of MDS Nurse several times since she started. The Administrator stated due to the changes in personnel, the MDS assessments were behind and were not completed in a timely manner. An interview with the Director of Nursing on 6/14/24 at 4:10 PM revealed there was a problem with the MDS Assessments not being completed in a timely manner due to staffing changes.	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a	F 640		7/27/24

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facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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F 640	Continued From page 57 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit the quarterly Minimum Data Set within the required time frame for 1 of 26 resident assessments reviewed (Resident #5). Findings included: Resident #5 was admitted into the facility on 12/17/20. Resident #5's medical record revealed his quarterly Minimum Data Set dated 04/15/24 was signed as completed on 04/15/24 with a transmission date of 06/11/24. An interview was conducted on 06/17/24 at 1:37 PM with the Minimum Data Set Coordinator. She stated she was aware that the quarterly Minimum Data Set for Resident #5 had not been transmitted within the designated time frame. She stated she knew Resident #5's MDS was transmitted late. An interview was conducted on 06/14/24 at 11:15 AM with the Administrator. She indicated that all Minimum Data Sets should be transmitted in a timely manner as required.	F 640	The facility failed to transmit the quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 26 resident assessments reviewed (Resident #5). All quarterly MDS assessments have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will review the quarterly MDS assessments for all residents, from March of 2024, to ensure they were all transmitted timely by 8/5/2024. The DON or Designee will educate the MDS Coordinator and all staff who are responsible for completing sections on the MDS assessment by 8/5/2024 on the importance of timely transmission of the quarterly MDS assessments to ensure they are transmitted in the required timeframe. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit all quarterly MDS assessments on a weekly basis for 4	

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F 640	Continued From page 58	F 640	weeks (Monday - Friday) to ensure all quarterly MDS assessments are transmitted within the required timeframe. Any issues with late transmission of quarterly MDS assessments will result in re-education with the appropriate staff members and additional training. Beginning 7/27/2024, the DON or Designee will audit all "In Progress" quarterly MDS assessments monthly for three months to ensure timely transmission of the assessments. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		7/27/24

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F 641	Continued From page 59 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 26 residents reviewed (Resident #50, Resident #61, and Resident #8). Findings included: 1. Resident #50 was admitted to the facility on 10/06/23. Diagnoses included peripheral vascular disease, and diabetic foot ulcer. Review of pharmacy consultant notes written on 01/22/24 and 02/15/24 revealed the resident had a diagnosis of diabetic foot infection and chronic inflammatory polyneuropathy. The Minimum Data Set (MDS) quarterly assessment dated 03/08/24 did not have Resident #50 coded as having a venous or arterial ulcer or as having a diabetic foot ulcer. Review of the care plan dated 03/08/24 revealed Resident #50 had a plan of care for diabetes mellitus with interventions to include inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness; and a plan of care for potential pressure area related to decreased mobility and peripheral vascular disease with interventions to include monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs or symptoms of infection to physician and weekly treatment documentation to include measurement of each area of skin breakdown, width, length, depth, type of tissue and exudate and other notable changes or observations. A review of the physician's order written on	F 641	The facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 26 residents reviewed (Resident #50, Resident #61, and Resident #8). All MDS assessments have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON), MDS coordinator, or Designee will review all assessments scheduled after 7/1/2024 for current residents to ensure proper coding was completed accurately by 8/5/2024. The DON or Designee will educate the MDS coordinator by 8/5/2024 on the importance of MDS assessment coding accuracy. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit all MDS assessments to ensure all MDS assessments are coded accurately. Any issues of coding accuracy will result in re-education and additional training for the MDS coordinator and any other appropriate staff members. Beginning 7/27/2024, the DON or Designee will audit all MDS assessments monthly for 3 months to ensure they have been coded accurately. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the	

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F 641	Continued From page 60 10/23/23 revealed an order to cleanse left heel topically with a topical medication every Monday, Wednesday and Friday for wound healing. This was discontinued on 05/10/24. A phone interview was conducted with the remote MDS nurse on 06/18/24 at 12:59 PM revealed she was a contract employee and had been at the facility since April 30, 2024. She stated she worked remotely and she had access to the electronic medical records so she could complete the assessments based on the documentation in the look back period. She stated she reviewed physician orders, diagnoses, nursing progress notes and nursing assessments in order to accurately code the MDS. She added, she did not do any actual face to face assessments. She stated she was able to retrieve the information about the resident by reviewing the documentation. The remote MDS nurse reviewed Resident #50's medical record at this time and confirmed that he was admitted with a diabetic foot ulcer and was receiving treatments for this wound since admission. The remote MDS nurse stated she should have coded him as having a diabetic foot ulcer. A phone interview was conducted on 06/19/24 at 4:00 PM with the Administrator. The Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for accurately coding the MDS assessments. 2. Resident #61 was admitted on 1/11/2024 to the facility. Diagnoses included a condition in which the immune system attacks the nerves and pain. A review of the physician's orders recorded an	F 641	results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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F 641	Continued From page 61	F 641		

order for Methadone HCL (a long acting opioid medication) 5 milligrams (mg) two tablets twice a day for pain was written on 2/1/2024 for Resident #61.

The April 2024 Medication Administration Record (MAR) recorded Resident #61 was receiving Methadone HCL twice a day.

The quarterly Minimum Data Set (MDS) assessment dated 4/18/2024 indicated Resident #61 was cognitively intact and was not receiving opioids (pain relieving medications).

Resident #61's care plan dated 6/11/2024 included a focus for pain. Interventions included administering analgesics (medications that relieve pain) per physician orders and to evaluate the effectiveness in relieving pain.

The June 2024 MAR recorded Resident #61 continued to receive Methadone HCL 5 mg twice a day.

On 6/19/2024 at 11:19 a.m. in a phone interview with the Remote MDS Nurse for the facility, she explained based on her notes from reviewing Resident #61's electronic medical record (EMR) when completing the MDS assessment, Resident #61 was not on any opioids. After the Remote MDS Nurse reviewed Resident #61's EMR, she stated Resident #61 was receiving Methadone, an opioid, daily when the quarterly assessment dated 4/18/2024 was completed. She said she missed coding Resident #61's MDS assessment for opioid. She explained it was an oversight or a stroke of the computer key error.

On 6/19/2024 at 10:22 a.m. in a phone interview

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F 641	Continued From page 62	F 641		

with the Director of Nursing (DON), she explained due to the inconsistency of having a MDS nurse in the facility, the facility was using a Remote MDS nurse to complete MDS assessments. She explained the Remote MDS Nurse used information in the EMR that could lead to inadequate MDS assessment of Resident #61 use of opioids. The DON stated she had not conducted any monitoring related to the accuracy of completed MDS assessments by the Remote MDS Nurse.

On 6/19/2024 at 12:25 p.m in a phone interview with the Administrator, she stated the DON oversaw MDS assessments to ensure completed correctly, and Resident #61's MDS assessment should had included the use of opioids.

3. Resident #8 was admitted to the facility on 8/19/23 with diagnoses which included chronic atrial fibrillation.

Review of Resident #8's Physician Orders revealed an order for Rivaroxaban (a blood thinner) 5 mg every day for chronic atrial fibrillation written on 8/19/23.

Resident #8's Medication Administration Record 8/19/23 was reviewed and indicated she received Rivaroxaban 5 mg by mouth daily since she was admitted to the facility on 8/19/23.

Review of the quarterly Minimum Data Set (MDS) Assessment dated 5/24/24 indicated Resident #8 was not coded as receiving anticoagulants on a scheduled or routine basis.

During an interview with the MDS nurse on 6/17/24 at 10:08 am she further indicated she

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F 641	Continued From page 63 was completing MDS assessments remotely. She also indicated it could have been not coded for anticoagulant use in error. In an interview with the Administrator on 6/17/24 at 11:07 am she indicated the MDS should be coded and processed accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		7/27/24

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F 655	Continued From page 64 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an individualized person-centered baseline care plan within forty-eight hours of admission for 2 of 26 residents reviewed for care planning (Resident #16 and Resident #319). Findings included: 1. a. Resident #16 was admitted to the facility on 4/26/2024 with diagnoses including stroke. The physician's orders dated 4/26/2024 included an order for rivaroxaban (an anticoagulant medication that prevents or break down blood clots) 20 milligrams(mg) via gastrostomy tube (G-Tube) in the evening for anticoagulation. Resident #16's April 2024 Medication Administration Record (MAR) recorded rivaroxaban 20 milligrams (mg) was administered 4/27/2024, 4/28/2024 and 4/29/2024.	F 655	The facility failed to develop an individualized person-centered baseline care plan within forty-eight hours of admission for 2 of 26 residents reviewed for care planning (Resident #16 and Resident #319). All individualized person-centered baseline care plans within forty-eight hours of a residents admission have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will review the individualized person-centered baseline care plans for all residents, from March of 2024, to ensure they were all completed timely by 8/5/2024. The DON or Designee will educate the MDS coordinator and all staff who are responsible for completing sections on the	

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F 655	Continued From page 65 There was no individualized person-centered baseline care plan located in Resident #16's medical record for the 4/26/2024 admission. Nursing documentation dated 4/29/2024 at 8:25 p.m. reported Resident #16 was coughing up blood and bleeding profusely from the nose. Emergency Medical Services (EMS) was called to transport Resident #16 to the hospital. b. Resident #16 was re-admitted to the facility on 5/9/2024. The 5-day admission Minimum Data Set (MDS) assessment dated 5/15/2024 indicated Resident #16 was severely impaired cognitively and was not coded for receiving anticoagulants. Resident #16's May 2024 Medication Administration Record (MAR) recorded rivaroxaban 20 milligrams (mg) was restarted on 5/9/2024 and administered every evening from 5/9/2024 to 5/31/2024 except for 5/29/2024. Resident #16's June 2024 MAR recorded rivaroxaban 20 mg was administered every evening from June 1, 2024, to June 13, 2024 except on 6/5/2024 and 6/9/2024 when Resident #16 was out of the facility. There was no individualized person-centered baseline care plan located in Resident #16's medical record for the 5/9/2024 admission. On 6/19/2024 at 11:19 a.m. in a phone interview with the Remote MDS Nurse for the facility, she explained she was hired by the facility to work remotely and to complete MDS assessments. She stated the nursing staff at the facility were	F 655	MDS assessment by 8/5/2024 on the importance of timely completion of the individualized person-centered baseline care plans to ensure they are completed in the required timeframe. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit individualized person-centered baseline care plans to ensure all individualized person-centered baseline care plans are completed within the required timeframe. Any issues with late submissions will result in re-education with the appropriate staff members and additional training. Beginning 7/27/2024, the DON or Designee will audit all individualized person-centered baseline care plans monthly for 3 months to ensure timely transmission of the assessments. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified	

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F 655	Continued From page 66 responsible for completing individualized person-centered baseline care plans for residents and the individualized person-centered baseline care plan was active until the MDS Nurse completed the comprehensive care plan. She stated Resident #16 was receiving anticoagulants on admission, and an individualized person-centered baseline care plan should have been completed within the first forty-eight hours of admission. On 6/19/2024 at 10:22 p.m. during a phone interview with the Director of Nursing (DON), she stated the MDS Nurse located at the facility was responsible for completing the individualized person-centered baseline care plans. The DON explained there had not been a consistent MDS Nurse at the facility since before March 2024. She stated there was only one MDS Nurse, and individualized person-centered baseline care plans were not being completed because the MDS Nurse was working on completing the back log of MDS assessments. The DON stated Resident #16 should have had an individualized person-centered baseline care plan started within two hours of admission to the facility. On 6/19/2024 at 12:25 p.m. during a phone interview with the Administrator, she explained although the MDS Nurse at the facility was the responsible person to complete the individualized person-centered baseline care plan after admission, licensed nurses could start an individualized person-centered baseline care plan. She further explained the administration team decided since March 2024 to transition the licensed nursing staff to start resident's individualized person-centered baseline care plans and was just realizing the transition had not	F 655	timeframe as described in this corrective action.	

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F 655	Continued From page 67 occurred. 2. Resident #319 was admitted to the facility on 4/23/24 with diagnoses which included type 2 Diabetes Mellitus, aphasia, and a recent history of a cerebral vascular accident (stroke) with hemiplegia (loss of strength or almost complete weakness on one side of the body). A review of Resident #319's Electronic Medical Record (EMR) revealed no baseline care plan. Review of Resident #319's admission Minimum Data Set (MDS) revealed admission assessment completed on 5/1/24. During an interview with the Remote MDS nurse on 6/17/24 at 10:08 am she revealed that assessments were completed late because the previous nurse could not get caught up. She further indicated she was completing MDS assessments remotely. During a phone interview with the Director of Nursing (DON) on 6/18/24 at 11:14 am she stated the MDS nurse was responsible for developing the baseline care plan within 48 hours. She further stated she did not know why this was not completed upon Resident #319's admission. In a phone interview with the Administrator on 6/18/24 at 9:03 am she stated Resident #319's admission MDS assessment should have been completed within the regulatory time frame.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		7/27/24

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F 656	Continued From page 68 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 69 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to develop and implement a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include: the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration (Resident #11), at risk for nutritional status (Resident #219 and Resident #34), assistance with activities of daily living, nutrition, and urinary incontinence (Resident #52); and for not developing a comprehensive care plan for a resident receiving anticoagulant medication (blood thinner) (Resident #16). This was for 5 of 26 residents reviewed. Finding included: 1. Resident #11 was admitted to the facility on 08/11/23 with diagnoses including in part; dementia, hearing loss, and cerebral vascular accident (CVA). The Minimum Data Set (MDS) admission assessment dated 08/17/23 revealed Resident #11 had moderately impaired cognition. He had moderate difficulty hearing, and difficulty communicating some words or thoughts. He had impaired vision and used corrective lenses. He had no falls and was at risk for falls. No pressure ulcers and at risk of pressure ulcers. He had	F 656	The facility failed to develop and implement a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include: the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration (Resident #11), at risk for nutritional status (Resident #219 and Resident #34), assistance with activities of daily living, nutrition, and urinary incontinence (Resident #52); and for not developing a comprehensive care plan for a resident receiving anticoagulant medication (blood thinner) (Resident #16). This was for 5 of 26 residents reviewed. All person-centered comprehensive care plans have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee will review the person-centered comprehensive care plans for all residents, from March of 2024, to ensure they were all developed and implemented by 8/5/2024. The DON or Designee will educate the MDS coordinator and all staff who are	

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F 656	Continued From page 70 broken teeth and received pain medication. He required assistance with activities of daily living. The care area assessment dated 08/17/23 indicated to initiate care plans in the following areas: psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration. Review of Resident #11's electronic medical record from admission on 08/11/23 through 06/19/24 revealed no care plan in place for Resident #11 to address psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, or dehydration. During a phone interview on 06/19/24 at 2:05 PM the MDS nurse stated she worked for an agency that was contracted with the facility and completed MDS assessments and care plans remotely. She began working for the facility on 04/30/24. She indicated although she was not the person that was responsible for creating the initial comprehensive care plan for Resident #11, the care plans should have been completed from the care areas that triggered on the MDS admission assessment. She reviewed the MDS and care plan for Resident #11 and agreed a care plan should have been implemented in the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, or dehydration. During an interview on 06/14/24 at 4:00 PM the Director of Nursing (DON) stated she was not aware that care plans were not implemented for Resident #11. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented	F 656	responsible for completing sections on the MDS assessment by 8/5/2024 on the importance of developing and implementing the person-centered comprehensive care plans to ensure residents are receiving quality care. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit all person-centered comprehensive care plans to ensure they are all completed. Any issues with late submissions will result in re-education with the appropriate staff members and additional training. Beginning 7/27/2024, the DON or Designee will audit all person-centered comprehensive care plans monthly for three months to ensure the development and implementation of the person-centered comprehensive care plan assessments. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the	

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F 656	Continued From page 71 according to the required CMS (Centers for Medicare & Medicaid) guidelines. During a phone interview on 06/19/24 at 4:00 PM the Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and care plans should have been initiated for Resident #11. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible. 2. Resident #219 was admitted to the facility on 05/22/24 with diagnosis including cellulitis of the left lower limb and diabetes. The MDS admission assessment dated 05/28/24 revealed Resident #219 was cognitively intact. She received wound care and a therapeutic diet. The care area assessment dated 05/28/24 indicated to initiate a care plan that included nutritional status. Review of Resident #219's electronic medical record from admission on 05/22/24 through 06/19/24 revealed no care plan in place for Resident #219 to address Nutritional status with measurable goals and interventions. During a phone interview on 06/19/24 at 2:05 PM the MDS nurse stated she was responsible for initiating the comprehensive care plan for Resident #219. She reported that she missed initiating the care plan as indicated on the MDS admission assessment in the area of nutrition. She stated it was done in error. During an interview on 06/14/24 at 4:00 PM the	F 656	audits will continue for the specified timeframe as described in this corrective action.	

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Director of Nursing (DON) stated she was not aware that care plans were not implemented for Resident #219. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines.

During a phone interview on 06/19/24 at 4:00 PM the Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and care plans should have been initiated for Resident #219. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible.

3. Resident #52 was admitted to the facility on 05/02/24. Diagnoses included, in part, dementia, seizures, syncope and chronic kidney disease.

The Minimum Data Set (MDS) admission assessment dated 05/09/24 revealed Resident #52 was severely cognitively impaired and required assistance with activities of daily living and was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #52's weight was recorded as 193 pounds and there were no nutritional approaches indicated. The care area assessment dated 05/09/24 indicated to initiate care plans in the following areas: activities of daily living, urinary incontinence, and nutritional status.

Review of Resident #52's electronic medical record from admission on 05/02/24 through 06/19/24 revealed there were no care plans in place to address nutritional status, activities of

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F 656	Continued From page 73	F 656		

daily living, or urinary incontinence.

An interview was conducted on 06/14/24 at 4:00 PM with the Director of Nursing (DON). The DON stated she was not aware that care plans were not implemented for Resident #52. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines.

A phone interview was conducted on 06/19/24 at 2:05 PM with the MDS nurse. The MDS nurse stated she worked for an agency that was contracted with the facility and completed MDS assessments and care plans remotely. She began working for the facility on 04/30/24. She indicated although she was not the person that was responsible for creating the initial comprehensive care plan for Resident #52, the care plans should have been completed from the care areas that triggered on the MDS admission assessment. She reviewed the MDS and care plan for Resident #52 and agreed a care plan should have been implemented in the areas of nutritional status, activities of daily living and urinary incontinence.

A phone interview was conducted on 06/19/24 at 4:00 PM with the Administrator. The Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and care plans should have been initiated for Resident #52. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible.

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4. Resident #34 was admitted to the facility on 02/01/24. Diagnoses included, in part, cancer, anxiety and depression, acquired absence of kidney, and dementia.

The MDS admission assessment dated 02/08/24 revealed Resident #34 was moderately cognitively impaired; weight was recorded as 155 pounds and he was on a mechanically altered diet.

The MDS quarterly assessment dated 04/07/24 revealed Resident #34 was moderately cognitively impaired. Resident #34 was coded as coughing or choking during meals or when swallowing medications and weight was recorded as 139 pounds. Resident #34 had a weight loss of 5% or more in the last month or a loss of 10% or more in last 6 months and was on a mechanically altered diet.

Review of Resident #34's electronic medical record from admission on 02/01/24 through 06/19/24 revealed there was no care plan in place to address nutritional status.

An interview was conducted with the DON on 06/14/24 at 4:00 PM. The Director of Nursing (DON) stated she was not aware that the nutritional care plan was not implemented for Resident #34. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines.

A phone interview was conducted on 06/19/24 at 2:05 PM with the MDS nurse. The MDS nurse

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stated she worked for an agency that was contracted with the facility and completed MDS assessments and care plans remotely. She began working for the facility on 04/30/24. She indicated although she was not the person that was responsible for creating the initial comprehensive care plan for Resident #34, the care plans should have been completed from the care area that triggered on the MDS admission assessment. She reviewed the MDS and care plan for Resident #34 and agreed a care plan should have been implemented for nutritional status.

A phone interview was conducted on 06/19/24 at 4:00 PM with the Administrator. The Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and the care plan should have been initiated for Resident #34. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible.

5. Resident #16 was admitted to the facility on 4/26/2024 with diagnoses including stroke.

Physician's orders dated 4/26/2024 included an order for Xarelto (an anticoagulant medication that prevents or break down blood clots) 20 milligrams (mg) via gastrostomy tube (G-Tube) in the evening for anticoagulation.

Resident #16's April 2024 Medication Administration Record (MAR) recorded Xarelto 20 mg was administered 4/27/2024, 4/28/2024 and 4/29/2024.

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Nursing documentation dated 4/29/2024 at 8:25pm reported Resident #16 was coughing up blood and bleeding profusely from the nose. Emergency Medical Services (EMS) was called to transport Resident #16 to the hospital.

Resident #16 was discharged to the hospital on 4/29/2024 and was re-admitted to the facility on 5/9/2024.

The 5-day admission Minimum Data Set (MDS) assessment dated 5/15/2024 indicated Resident #16 was severely impaired cognitively. The Resident #16's MDS was not coded for receiving anticoagulants.

Resident #16's comprehensive care plan dated 5/15/2024 did not include a focus for the use of anticoagulants.

Resident #16's MAR from 5/9/2024 through 6/13/2024 revealed Resident #16 received Xarelto 20 mg as ordered.

On 6/19/2024 at 11:19 am in a phone interview with the Remote MDS Nurse, she explained she was responsible for completing the comprehensive care plans after completing the MDS assessment. She stated based on the physician's order and documentation of administration of the Xarelto daily, the use of anticoagulants should have been included on the comprehensive care plan for Resident #16. She said it was an oversight on her part.

On 6/19/2024 at 10:22 am in a phone interview with the Director of Nursing (DON), she explained the Remote MDS nurse or MDS Nurse at the

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F 656	Continued From page 77 facility was responsible for updating Resident #16's comprehensive care plan to include the use of anticoagulants and stated Resident #16 should have been care planned for the use of anticoagulants. The DON explained due to resignations of previous MDS nurses since March 2024 and a back log of MDS assessments to complete, the MDS nurses were unable to dedicate sufficient time in developing a comprehensive care plan for Resident #16. On 6/19/2024 at 12:25 pm in a phone interview with the Administrator, she stated the Director of Nursing was responsible to ensure the MDS nurses completed Resident #16's comprehensive care plan to included anticoagulants.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		7/27/24

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F 657	Continued From page 78 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, resident representative interviews, and staff interviews, the facility failed to ensure the resident and/or the responsible party was involved in the care planning process (Resident #61 and Resident #16), to revise a resident's care plan with new fall interventions (Resident #47), and to develop a care plan within 7 days after completion of the comprehensive assessment (Resident #319). This deficient practice affected 4 of 26 residents reviewed for care planning. Findings included: 1. a. Resident #61 was admitted to the facility on 1/11/2024. The quarterly Minimum Data Set (MDS) assessment dated 4/18/2024 indicated Resident #61 was cognitively intact. There was no documentation of the facility having a care plan meeting with Resident #61 or Resident #61's Representative in Resident #61's medical record. On 6/10/2024 at 2:00pm in an interview with Resident #61, he stated since his admission to the facility he had not had a care plan meeting with the different disciplines involved in his care to	F 657	The facility failed to ensure the resident and/or the responsible party was involved in the care planning process (Resident #61 and Resident #16), to revise a resident's care plan with new fall interventions (Resident #47), and to develop a care plan within 7 days after completion of the comprehensive assessment (Resident #319). This deficient practice affected 4 of 26 residents reviewed for care planning. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee will review the care plans for all residents, from March of 2024, to ensure the resident and/or the responsible party was involved in the care planning process, care plans have been revised to ensure new interventions are developed, care planned, and implemented, and to ensure timely completion of the care plans to ensure they are completed in the required timeframe by 8/5/2024.	

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F 657	Continued From page 79 discuss a plan of care to prepare him for a discharge to the community. On 6/14/2024 at 11:23 am in an interview with the Social Worker, she explained she and the former MDS Nurse in the facility provided dates each month to the receptionist to schedule initial care plan meetings after residents were admitted to the facility. She stated she could not recall having a care plan meeting with Resident #61 and did not know why Resident #61's initial admission care plan meeting was not conducted in January 2024. She explained the facility did not have a process established indicating who was responsible for resident care plan meetings and stated not having a MDS Nurse located in the facility served as a barrier in communicating when care plan meetings were to be conducted. She said Resident #61's quarterly care plan meeting had not occurred because care plan meetings were not being conducted at the facility due to not having a consistent MDS Nurse. On 6/14/2024 at 3:14 pm in an interview with the Director of Nursing, she said she could not recall attending a care plan meeting for Resident #61 and was unable to locate documentation in Resident #61's medical record that a care plan meeting was conducted. b. Resident #16 was admitted to the facility on 4/26/2024, discharged from the facility on 4/29/2024 to the hospital, and readmitted on 5/9/2024 to the facility. The 5-day admission Minimum Data Set (MDS) assessment dated 5/15/2024 indicated Resident #16 was severely cognitively impaired.	F 657	The DON or Designee will educate the MDS coordinator and all staff who are responsible for completing sections on the MDS assessment by 8/5/2024 on the importance of resident and/or responsible party involvement when developing the care plan. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will educate the MDS coordinator and all staff who are responsible for completing sections on the MDS assessment by 8/5/2024 on the importance of revising care plans to ensure new interventions are developed, care planned, and implemented. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will educate the MDS coordinator and all staff who are responsible for completing sections on the MDS assessment by 8/5/2024 on the importance of timely completion of the care plan to ensure they are completed in the required timeframe. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit all care plans to ensure the resident and/or the responsible party was involved in the care planning process, care plans have been revised to ensure new interventions are developed,	

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F 657	Continued From page 80 There was no documentation of a care plan meeting with Resident #16's Representative in Resident #16's medical record. On 6/10/2024 at 3:33 pm in a phone interview with Resident #16's Representative, she said the facility had not conducted a care plan meeting to discuss a plan of care with Resident #16's Representatives. She reported that Resident #16 was not able to communicate his needs. On 6/14/2024 at 11:23 am in an interview with the Social Worker, she explained she and the former MDS Nurse in the facility provided dates each month to the receptionist to schedule initial care plan meetings after residents were admitted to the facility. She stated she could not recall having a care plan meeting with Resident #16 or Resident #16's Representatives. She explained the facility did not have a process established indicating who was responsible for resident care plan meetings and stated not having a MDS Nurse located in the facility served as a barrier in communicating when care plan meetings were to be conducted. She said Resident #16's initial admission care plan meeting had not occurred because care plan meetings were not being conducted at the facility due to not having a consistent MDS Nurse. On 6/14/2024 at 3:14 pm in an interview with the Director of Nursing, she said she could not recall attending a care plan meeting for Resident #16 or with Resident #16's Representative and was unable to locate documentation in Resident #16's medical record that a care plan meeting was conducted to develop a individualized plan of care for Resident #16.	F 657	care planned, and implemented, and to ensure timely completion of the care plans to ensure they have been completed in the required timeframe. If any issues are identified the appropriate staff members will be re-educated and additional training will be provided. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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F 657	Continued From page 81 On 6/13/2024 at 5:55 pm in an interview with the Social Worker, Director of Nursing (DON) and Administrator present, the Social Worker stated care plan meetings were recorded in the resident's medical record by herself (Social Worker) or the MDS Nurse, and the Remote MDS Nurse was not at the facility to conduct care plan meetings. The DON stated due to the MDS Nurse working remotely, care plan meetings were not held. The Administrator stated the DON was responsible for ensuring care plan meeting were conducted as scheduled. In a follow-up interview conducted with the DON by phone on 6/19/2024 at 10:22 am, she explained since March 2024 when she started at the facility, there had not been a MDS Nurse in the facility consistently to coordinate care plan meetings with the Social Worker. On 6/19/2024 at 12:25 pm in a phone interview with the Administrator, she explained the MDS coordinator was responsible for coordinating, scheduling and communicating to the interdisciplinary team members, residents and resident representatives when care plan meetings were to be conducted for residents. She stated when she started at the facility in February 2024, there was not a clear process for conducting care plan meetings. She reported she had been busy searching for staff to fill the MDS vacant position since she had not been able to find a permanent MDS Nurse. She said the Director of Nursing was responsible for the MDS department and ensuring care plan meetings were conducted to discussed with residents and/or residents' representatives the development and implementation of an individualized person centered residents' care plans.	F 657		

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2. Resident #47 was admitted to the facility on 12/13/2021.

The quarterly Minimum Data Set (MDS) assessment dated 2/1/2024 indicated Resident #47 was cognitively intact, required assistance from a sitting to a standing position and independently could walk up to fifty feet and self-propel a manual wheelchair.

A review of Resident #47's fall incident reports dated 4/16/2024 and 5/29/2024 indicated the following:
- On 4/16/2024 the resident sustained a fall and a new intervention was implemented to request for Programs of All-Inclusive Care for the Elderly (PACE) to perform a medication review.
- On 5/29/2024 the resident sustained a fall and a new intervention was implemented to remind resident not to stand from the wheelchair alone without two-person assist.

On 6/11/2024, the quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/3/2024 was recorded as still in process.

Resident #47's care plan dated 12/14/2021 and last reviewed on 6/11/2024 indicated Resident #47 had a history of falling and was at risk for falling that could result in an injury due to impaired mobility and use of psychotropic medications (medications that affect the brain chemicals involved in mental health disorders). Interventions included keeping the bed in lowest position, keeping the call bell within reach and encouraging Resident #47 to use the call bell to request assistance to get out of the bed. The goals for falls included free of injury and free of

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falls until next review date. The interventions indicated on the incident reports for the 4/16/2024 and 5/29/2024 falls were not included on this care plan that was last reviewed on 6/11/2024.

On 6/13/2024, the new interventions from the 4/16/1024 and 5/29/2024 falls were added to Resident #47's care plan.

On 6/19/2024 at 11:19 am in a phone interview with Remote MDS Nurse, she stated she updated or completed comprehensive care plans after the MDS assessment was completed, and Resident #47's comprehensive care plan for falls was updated on 6/13/2024 after the quarterly assessment with an ARD date of 5/3/2024 was completed and sent for processing. She explained Resident #47's comprehensive care plan was a live documentation tool and nursing staff at the facility was responsible for updating Resident #47's care plan to record falls and new interventions. The Remote MDS Nurse stated she didn't see where Resident #47's care plan had been updated and based on the documentation in Resident #47's electronic medical record, she had updated the care plan for falls on 6/13/2024.

On 6/19/2024 at 10:22 am in a phone interview with the Director of Nursing (DON), she stated the MDS Nurse in the facility attended a risk meeting held after the clinical morning meetings to discuss falls, and the MDS Nurse was responsible for updating Resident #47's care plan after a fall was reported and new interventions implemented. She said the MDS Nurse and herself (the DON) updated resident care plans. She explained that due to the inconsistency of a MDS Nurse in the facility and with the back log

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MDS assessments that needed completed, the MDS Nurse had not been able to make revisions in Resident #47's care plan. She stated she had not updated Resident #47's care plan with the new interventions on 4/16/2024 and 5/29/2024 and did not provide a reason for not updating the care plan. She also stated she had not communicated with the Remote MDS Nurse to make revisions to Resident #47's fall care plan

On 6/19/2024 at 12:25 pm in a phone interview with the Administrator, she stated the Director of Nursing and the MDS nurse were responsible for developing and updating Resident #47's care plan to prevent falls. She explained the MDS Nurse assigned to work in the facility was learning the MDS process and working on the back log of MDS assessments that needed to be completed and she thought the DON was transitioning the staff nurses to help with the development and revision of resident care plans, but the transition had not occurred.

3. Resident #319 was admitted to the facility on 4/23/24 with diagnoses which included type 2 Diabetes Mellitus, aphasia, and a recent history of a cerebral vascular accident (stroke) with hemiplegia (loss of strength or almost complete weakness on one side of the body).

Review of Resident #319's admission Minimum Data Set (MDS) revealed the admission assessment completed on 5/1/24.

A review of Resident #319's electronic medical record (EMR) revealed no care plan was intiated until 6/13/24.

During an interview with the Remote MDS nurse

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F 657	Continued From page 85 on 6/17/24 at 10:08 am she revealed that assessments were completed late because the previous nurse could not get caught up. She further indicated she was completing MDS assessments remotely. During a phone interview with the Director of Nursing (DON) on 6/18/24 at11:14 am she stated the MDS nurse was responsible for developing the care plans. She further stated she did not know why this was not completed for Resident #319. In an interview with the Administrator on 6/17/24 at 11:07 am she indicated the care plans should be completed within the regulatory timeframe.	F 657		
F 684 SS=E	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 observations, record review, and resident, staff, and Wound Care Physician's interviews the facility failed to 1) perform daily wound care treatments to a non-pressure diabetic foot ulcer and implement a hind off-loading boot (a specific boot to reduce pressure on a specific part of the foot to allow a wound to heal) according to the Wound Care Physicians' orders	F 684	The facility failed to 1) perform daily wound care treatments to a non-pressure diabetic foot ulcer and implement a hind off-loading boot according to the Wound Care Physicians' orders for 1 of 3 residents (Resident #50) observed for wound care; and 2) follow physician orders to change an intravenous (IV) site	7/27/24

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F 684	Continued From page 86 for 1 of 3 residents (Resident #50) observed for wound care; and 2) follow physician orders to change an intravenous (IV) site every 3 days and to provide an intervention to establish IV access for a resident ordered to receive long term antibiotic therapy for 1 of 1 resident reviewed for IV medication administration (Resident #419). Findings included: 1. Resident #50 was admitted to the facility on 10/06/23. Diagnoses included right below the knee amputation, peripheral vascular disease, left leg cellulitis, and diabetic foot ulcer. The Minimum Data Set (MDS) quarterly assessment dated 03/08/24 revealed resident was cognitively intact and demonstrated no behaviors. Resident #50's was not coded as having a pressure ulcer, venous and arterial ulcer or as having a diabetic foot ulcer. Review of the care plan updated on 05/09/24 revealed Resident #50 had a plan of care for diabetes mellitus with interventions to include, in part, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, and a plan of care for potential pressure area related to decreased mobility and peripheral vascular disease with interventions ton include monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs or symptoms of infection to physician and weekly treatment documentation to include measurement of each area of skin breakdown, width, length, depth, type of tissue and exudate and other notable changes or observations. Review of the wound treatment assessments	F 684	every 3 days and to provide an intervention to establish IV access for a resident ordered to receive long term antibiotic therapy for 1 of 1 resident reviewed for IV medication administration (Resident #419). The facility responded to the above-mentioned issues as follows for Resident #50; the hind off-loading boot was ordered on 6/26/2024 and was delivered on 6/28/2024 when the new Director of Nursing (DON) was hired. Resident #419 was discharged from the facility on 4/5/2024; therefore, no further action could be taken as of 7/27/2024. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The DON or Designee will educate all nursing staff by 8/5/2024 on the importance of following providers orders as they are given to ensure all wounds are cared for appropriately, and to ensure all residents receive antibiotic therapy as ordered. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit all dressing changes 5 times per week for 12 weeks to ensure providers orders are being followed as given and to ensure all wounds are cared for appropriately. Any missed dressing	

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F 684	Continued From page 87 revealed the following measurements and wound orders for the diabetic wound of the left heel for Resident #50: On 04/30/24 the measurements to the left heel were recorded as 2.0 X 2.0 X 0.2 centimeters (cm) with indication the wound was improving. The treatment was silva sorb gel (antimicrobial agent), and xeroform (a pad applied to a wound to promote healing and protect the wound from harm) and wrap with kerlix. On 05/07/24 the measurements to the left heel were recorded as 2.6 X 2.6 X 0.2 (cm) with indication that the wound was unchanged. The treatment was to apply Medi honey (helps prevent bacteria from growing), silver alginate (antimicrobial) and cover with gauze daily. Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 05/20/24 revealed the measurements to the left heel were recorded as 2.8 X 2.8 X 0.3 (cm) with 40% slough and 60 % granulation tissue (healthy tissue) with a surface area of 7.84 (cm). The note indicated the wound was surgically debrided at this time and as a result of the procedure the wound bed decreased from 40 percent to 10 percent. The recommendations were to order a hind off-loading boot and apply Santyl (helps remove dead skin tissue and aides in wound healing) with xeroform and cover with gauze daily. A review of the physician's orders written on 05/21/24 revealed to cleanse wound with normal saline, apply Santyl with xeroform and secure with gauze daily. There was no order for a hind off-loading boot to the left heel wound.	F 684	changes will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the DON or Designee will audit all antibiotic usage 5 times per week for 12 weeks to ensure no missed doses occur. Any missed antibiotic administration will result in re-education and additional training with the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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Review of the Treatment Administration Record for May 2024 revealed on 05/25/24, the wound treatment order was not signed off as evidenced by nursing initials or a check mark. Additionally, there was no order on the Treatment Administration Record for a hind off-loading boot to left heel wound.

Record review revealed there was no documentation to support the dressing to the left heel wound was changed on Saturday 05/25/24.

Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 05/27/24 revealed the measurements to the left heel were recorded was 3.0 x 2.2 X 0.1 (cm) with 100 % granulation tissue (healthy tissue) with a surface area of 6.60 (cm). The note indicated the wound was improving as evidenced by decreased surface area. A recommendation for a hind off-loading boot was indicated.

An interview was conducted with Unit Manager (UM) #1 on 06/14/24 at 1:17 PM. UM # 1 revealed she was assigned to the hall Resident #50 resided on 05/25/24. She stated if a there was nothing charted in the treatment administration record on 05/25/24 then it meant that the treatment was not done. UM #1 reported she was not aware of an order for a hind off-loading boot for Resident #50.

Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 06/03/24 revealed the measurements to the left heel were recorded as 3.6 X 2.8 X 0.1 (cm) with indication

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the wound was unchanged. The treatment was changed to cleanse left heel with normal saline, apply calcium alginate and Medi honey and wrap with gauze daily. The note indicated the wound was surgically debrided at this time and as a result of the procedure the wound bed decreased from 20 percent to 0. The recommendation was to order a hind off-loading boot.

A review of the physician orders dated 06/03/24 revealed an order to cleanse left heel with normal saline, apply calcium alginate and Medi honey and wrap with gauze daily.

Review of the Treatment Administration Record for June 2024 revealed on 06/09/24 the wound treatment order was not signed off as evidenced by nursing initials or a check mark.

An interview and observation was conducted with Resident #50 on 06/10/24 at 1:00 PM. Resident #50 reported he was never given an off loading boot and when he inquired about it to the Director of Nursing she stated she did not know how to order the boot. Resident #50 also reported that in May, during the holiday weekend, his dressing to his left heel did not get changed. At this time, Resident #50 revealed the dressing to his left heel and added, the nurse had not changed the dressing since 06/08/24. The wound dressing was dated 06/08/24.

Observation of the wound dressing to the left heel on Resident #50 with the Wound Treatment Nurse was conducted on 06/12/24 at 2:30 PM. The wound was not measured at this time. There were no signs or symptoms of infection such as odor or drainage. Resident #50 had no complaints of pain.

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An interview was conducted with the Wound Treatment Nurse on 06/12/24 at 2:30 PM. The Wound Treatment Nurse stated the wound to Resident #50's left heel was debrided by the Wound Care Physician on 06/03/24 and the treatment was changed. She stated whenever a wound was debrided, the wound may appear that it was worsening with increased measurement size which was due to the debridement opening up the wound bed.

An interview was conducted with Unit Manager #2 on 06/14/24 at 2:00 PM. UM #2 reported she was assigned to Resident #50 on 06/09/24 and she should have changed the dressing as ordered to his left heel. She stated she was the nurse overseeing the medication aide and it was her responsible to do wound care since the medications aides were not allowed to perform wound care. Unit Manager #2 reported she was not aware of an order for a hind off loading boot for his left heel.

A phone interview was conducted with the previous Wound Care Physician on 06/17/24 at 1:00 PM revealed he was familiar with Resident #50 and his chronic heel wound. He stated he would have to refer back to his records but he stated based on what he could recall he felt that the wound was chronic and it was the same or slightly better but not getting worse. The Wound Care Physician was not able to complete the interview and stated he would return the call after he reviewed the medical record.

A follow up phone interview was conducted with the Wound Treatment Nurse on 06/17/24 at 2:11 PM. The Wound Treatment Nurse reported that

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when the Wound Care Physicians put in recommendations, they were considered orders and she would enter the orders into the electronic medical record. The Wound Treatment Nurse stated she was aware that Resident #50 had an order for the hind off-loading boot, but she was not sure why it was not ordered. The Wound Treatment Nurse stated the physician had classified the left heel wound as a diabetic ulcer since he was admitted to the facility and was acquired from his uncontrolled diabetes and peripheral vascular disease. The Wound Treatment Nurse added, she recalled letting the Director of Nursing (DON) know about the recommendation for the hind off-loading boot, but she did not follow up with the Director of Nursing to see what the status of the hind off-loading boot was or when it was going to be ordered.

An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 5:00 PM. The DON revealed she would expect wound treatments to be getting according to the physician's order to prevent infection or further debilitating a declining wound. The DON stated she did not know what a "hind off-loading" boot was and was working on trying to figure out where to order this type of boot with local wound supply companies.

A follow up call was placed to the previous Wound Care Physician on 06/18/24 at 1:57 PM. A message was left for a returned call.

Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 06/20/24 revealed the measurements to the left heel were recorded as 2.6 X 2.1 X 0.1cm with a surface

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area of 5.46 cm. Granulation tissue was noted to be at 100% with a note indicating the wound was healing as evidenced by a 45.8% decrease in surface area and 100% decrease in nonviable tissue within the wound bed and a recommendation was noted for a hind off-loading hind boot for left heel.

A phone interview was conducted with the Nursing Supervisor on 06/26/24 at 11:00 AM. The Nursing Supervisor stated she was made aware from the Wound Treatment Nurse about 2 weeks ago that a hind off loading boot was needed for Resident #50. She stated she and the previous DON were trying to figure out what type of boot this was by researching on line with local wound supply companies because they had never heard of it. She stated she spoke to the current Wound Care Physician on 06/25/24 to clarify the order for the hind off-loading boot and this physician sent her a link as to what the boot was and where to order it. She stated the current DON who started on 06/19/24 will be ordering the boot.

An interview with the current Director of Nursing via phone on 06/26/24 at 3:10 PM revealed she had started on 06/19/24 and it was brought to her attention on 06/25/24 from the Nursing Supervisor that Resident #50 needed the hind off-loading boot. The DON stated it should have been ordered by the previous DON. She added, she ordered the hind off-loading boot today and it will be in the facility on 06/28/24.

A phone interview with the current Wound Care Physician on 06/27/24 at 9:30 AM revealed she had been attending the facility since 06/14/24 and she did mention to the Wound Treatment Nurse

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that the hind off loading boot should be ordered for Resident #50. She stated it was not a unique type of boot or difficult to find and she could not speak to as to why it took so long for the boot get ordered. The Wound Care Physician stated she sent a link to the Nursing Supervisor of where to purchase the boot. She added, not having the boot would not contribute to the wound worsening, it was ordered as a protective device. She stated despite the resident not having the boot for the past month, his wound was healing but it should be ordered and utilized to add that extra protection. Additionally, the Wound Care Physician stated Resident #50's wound dressing was ordered daily and she would expect the dressing to get changed daily for continued wound healing.

2. Resident #419 was admitted to the facility most recently on 08/07/23.

Diagnoses included, in part, a sacral stage 4 pressure ulcer, and hemiplegia and hemiparesis following a stroke (cerebral infarction) affecting his dominant right side.

Review of a quarterly Minimum Data Set (MDS) assessment date 02/09/24 revealed Resident #419 had severely impaired cognition. Both upper and lower extremities on one side were impaired. He had one stage 4 pressure ulcer and one deep tissue injury that were not present on admission. He had received pressure ulcer care.

The care plan for Resident #419 revised on 03/05/24 documented a focus area of antibiotic therapy. The goal was for the resident to be free of any discomfort or adverse side effects of antibiotic therapy through the review date.

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Interventions included administering antibiotic medication as ordered by the physician and to monitor and document any side effects, the effectiveness, and any signs of secondary infection related to the antibiotic therapy.

2a. The March 2024 Medication Administration Record (MAR) revealed the following physician order: Change IV (intravenous) site every day shift every 3 day(s) for infection control-Start date 03/01/24; End date 03/23/24. The MAR was coded "5" on 03/04/24 (indicating the IV site change was held) and was left blank on 03/10/24.

Review of the progress notes dated 03/04/24 revealed Agency Nurse #6 documented the IV site change was to be held and that another nurse would change the IV site the following day.

In an interview with Agency Nurse #6 on 06/26/24 at 12:10 PM she stated she was told on 03/04/24 not to change Resident #419's IV site because a Registered Nurse would be at the facility the next day and she would change the IV site. She could not remember who told her to hold the IV site change and did not know if the site had been changed the next day.

Review of the progress notes and MAR for 03/05/24 revealed no documentation that the IV site for Resident #419 had been changed.

In an interview with Nurse #5 on 06/26/24 she stated she was familiar with Resident #419 but could not remember taking care of him on 03/10/24 or changing his IV site on that date. She stated that she was not normally on his assignment, and it was too long ago to recall.

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2b. Resident #419 had physician orders dated 2/23/24 for IV antibiotic daily for 4 weeks.

A progress note written by Agency Nurse #2 on 3/15/24 at 3:38 pm documented Resident #419's IV had infiltrated (came out of the vein and leaked fluid into the surrounding tissue) and she was not able to give the 1:00 pm dose of antibiotic. She made two unsuccessful attempts to restart the IV.

A progress note written by Nurse #13 on 03/16/24 at 12:28 am documented she attempted one time to place an IV in Resident #419's left forearm and was unsuccessful.

Progress notes written by Medication Aide #5 on 03/16/24 at 11:24 am and 12:14 pm documented Resident #419 did not receive his antibiotic medications because he did not have an IV.

A progress note written by Agency Nurse #2 on 03/17/24 at 4:36 pm documented an IV site was acquired and the antibiotics restarted. The MAR for 03/17/24 indicated Resident #419's antibiotics were not documented with a check mark that would have indicated the medications had been administered.

A progress note written by Agency Nurse #3 on 03/20/24 at 6:49 pm documented Resident #419 ' s IV had not been working since the beginning of the shift. She attempted to restart the IV three times and the charge nurse tried to restart the IV two times, but all 5 attempts were unsuccessful.

In an interview with Nurse #3 on 6/12/24 at 1:55 PM she stated while she was working the IV site stopped working and she tried to restart the IV but could not. She commented that Resident

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#419 was a "hard stick" (meaning it was difficult to start his IV). Another agency nurse on duty tried and could not get the IV started. She passed on in report to the next nurse the unsuccessful attempts to restart the IV. She noted the nursing supervisor on duty also tried to start the IV and could not. She did not know the names of the other two nurses but thought they were also from an agency. She cared for Resident #419 on 03/19/24 and 03/20/24.

A progress note written by Agency Nurse #2 on 03/22/24 at 3:51 pm documented she had tried to start an IV for Resident #419, but the attempt was unsuccessful.

In an interview with Agency Nurse #2 on 6/12/24 at 1:50 PM she stated she was not sure if she had tried to restart his IV access or not. She cared for Resident #419 on 03/15/24 and 03/22/24.

A progress note written by Nurse #13 on 03/23/24 documented Resident #419 did not receive his antibiotics because he had no IV access.

In an interview with the Wound Care Nurse on 06/12/14 at 12:30 PM she stated the Nurse Practitioner (NP) was aware the IV was out. She noted the NP was supposed to come to the facility and restart the IV. She cared for Resident #419 on 03/23/34.

In an interview with Nurse #20 on 07/01/24 at 10:10 am she stated she had cared for Resident #419 on 03/16/24, 03/19/24, and 03/21/24. She recalled when she assessed him to start an IV site, she could not find a vein.

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F 684	Continued From page 97 Multiple unsuccessful attempts were made to contact the NP on 06/12/14 at 1:48 PM and 3:36 PM. She had been employed at the facility in March 2024. An additional attempt was made on 06/13/24 at 3:07 PM with no response. Other attempts were made to contact the NP by different surveyors on the team throughout the survey week with no response. Multiple unsuccessful attempts were made on 06/12/14 at 1:50 PM and 3:33 PM to contact the physician employed at the facility in March 2024. An additional attempt was made on 06/13/24 at 3:00 PM with no response. Other attempts were made to contact the physician by different surveyors on the team throughout the survey week with no response. In an interview with the current Agency DON (Director of Nursing) on 06/12/24 at 1:05 PM she stated she became employed at the facility on 03/25/24. She commented if she had been employed when the facility nurses could not establish IV access, she would have first tried to start the IV herself and if unsuccessful she would have called the provider, obtained an order for a PICC line and would have sent the resident out to have IV access established within 24 hours of the first unsuccessful attempt to re-establish IV access.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		7/27/24

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F 686	Continued From page 98 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to assess, obtain physician orders for treatment, and communicate about the new pressure ulcer so assessments and treatments could be provided for 1 of 5 residents reviewed for pressure ulcers (Resident #119). Findings included: Resident #119's Hospital admission note dated 03/02/24 revealed resident with pressure ulcer of coccygeal region that was present on admission. Resident #119 was admitted from the hospital to the facility on 04/04/24. The diagnoses included diabetes, congestive heart disease, end stage renal disease, atrial fibrillation, and hypertension. Review of the head-to-toe skin assessment for Resident #119 dated 04/04/24 done by Nurse #2, identified and documented a "Sacrum - small, reddened area to bony prominence, pressure absorbent bandage in place." A nursing note dated 04/05/24 at 2:37 AM by Nurse #10 revealed Resident #119 admitted to facility via stretcher from hospital during day shift.	F 686	The facility failed to assess, obtain physician orders for treatment, and communicate about a new pressure ulcer so assessments and treatments could be provided for 1 of 5 residents reviewed for pressure ulcers (Resident #119). Resident #119 received wound care on 4/5/2024 which included cleaning with normal saline and the application of a dressing per nursing progress note that was dated on 4/5/2024. The wound care nurse for the facility received an order to start Calmoseptine twice a day on 4/6/2024 and it was entered into the Treatment Administration Record (TAR). Resident #119 was discharged from the facility to home per family request on 4/10/2024. Resident #119 was discharged with a referral to a wound care provider and with a hospice referral. The resident was discharged with an appointment to a wound care provider with the appointment being on 4/16/2024. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient	

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F 686	Continued From page 99 Resident was alert and oriented with some confusion noted and was able to verbalize needs. She had an open area noted to bony prominence of coccyx, and area was cleansed with normal saline and new dressing applied. A telephone interview was conducted with Nurse #10 on 06/12/24 at 10:35 AM. Nurse #10 stated she completed the initial admission skin assessment for Resident #119 on 04/04/24. Nurse #10 explained she noticed Resident #119 had a dressing in place from the hospital on her coccyx covering what looked like an open split skin area on her buttock crack near the sacrum. There was no drainage or odor. She said she removed the old dressing, cleaned the site with normal saline. She also said she did not recall documenting a description of her observation, but she was certain she informed the day nurse of her observation and dressing change and let the wound treatment nurse know of the site. A nursing note dated 04/05/24 at 1:36 PM by Nurse #1 revealed nurse went to assess Resident #119's skin, but she had left facility to go to dialysis and would be back later this PM. Review of the April 2024 Treatment Administration Record (TAR) for Resident #119 revealed the resident received treatment Calmoseptine to buttock with each incontinent episode, apply every day at night shift and to start 04/06/24 at 7:00 PM. The TAR had no documented treatment for the coccyx pressure ulcer. The admission Minimum Data Set (MDS) assessment dated 04/10/24 revealed Resident #119 had no cognitive impairments. She required	F 686	practice. The Director of Nursing (DON) or Designee, will review all current pressure wounds to ensure orders and treatments are being followed and will check the weekly skin checks from March of 2024, to ensure any new wounds have been identified and are being treated by 8/5/2024. The DON or Designee will ensure all current pressure wounds have been assessed, physician orders for treatment have been obtained, and communication has been completed regarding any new pressure ulcers; so assessments and treatments can be provided by 8/5/2024. The DON or Designee will educate all nursing staff by 8/5/2024 on the importance of skin checks upon admission, as well as routine weekly skin checks, to ensure all new skin issues are documented, reported, and treatment orders are obtained so treatment begins. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will educate all nursing staff by 8/5/2024 on the importance of off-loading residents to prevent the skin from breaking down. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation.	

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F 686	Continued From page 100 substantial/maximal physical assistance with bed mobility, transfers, and activities of daily living. She was always incontinent of bowel and frequently incontinent of bladder. Resident #119 was discharged to her home on 04/10/24. An interview was conducted on 06/12/24 at 10:00 AM with the Director of Nursing (DON). The DON stated Nurse #119 documented an observation of an open area noted to bony prominence of coccyx and she cleaned the area with normal saline and applied a new dressing. She acknowledged there was no documenation about Resident #119's coccyx ulcer from admission 04/04/24 through discharge on 04/10/24. An interview was conducted on 06/12/24 at 3:45 PM with Unit Manager #2 (previous treatment nurse). The Unit Manager stated on 04/05/24 the day nurse who received report from Nurse #10 should have reported Resident #119's sacral pressure ulcer to her for evaluation and possible treatment which she did not. An interview was conducted on 06/13/24 at 10:50 AM with the Administrator. She said it was her expectation that Resident #119's admission coccyx pressure ulcer should have been identified, treated, and tracked more closely by nursing staff. An interview was conducted on 06/14/24 at 10:20AM with the Nurse Practitioner (NP). She stated it was her expectation that on 04/05/24 the day nurse assigned to Resident #119 should have reported the coccyx pressure ulcer to the wound treatment nurse that same morning it was	F 686	Beginning 7/27/2024, the DON or Designee will audit weekly skin checks on 5 residents per week x 12 weeks to ensure any new skin breakdown has been identified. Any missed skin issues or missed weekly skin checks will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the DON or Designee will audit all new admission skin assessments to ensure all skin issues are identified upon arrival to the facility. Any missed skin issues or missed new admission skin assessments will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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F 686	Continued From page 101 reported to her and did not. The NP said all nursing staff are responsible for reporting all wounds timely to the treatment nurse so she can obtain appropriate orders and start treatment. NP stated it was important to her and the treatment nurse to know what wounds were in the facility and what treatments were being utilized, which had not happened in this case.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to supervise a dependent resident (Resident #50) when he was left alone in the shower room on the shower chair and waited for staff to answer the call light and provide assistance for 1 of 7 residents reviewed for accidents. Findings included: Resident #50 was admitted to the facility on 10/06/23. Diagnoses included right below the knee amputation with prothesis, coronary artery disease, high blood pressure, chronic kidney disease, and congestive heart failure. The Minimum Data Set (MDS) quarterly	F 689	The facility failed to supervise a dependent resident (Resident #50) when he was left alone in the shower room on the shower chair and waited for staff to answer the call light and provide assistance for 1 of 7 residents reviewed for accidents. Resident #50 did not endure any negative outcome from this incident and has not had any other incidents regarding being in the shower room alone reported. A skin assessment was completed on 5/18/2024 with no new skin issues reported. The resident did not report any additional occurrences and did not report any pain from the incident.	7/27/24

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F 689	Continued From page 102 assessment dated 02/20/24 revealed resident was cognitively intact and demonstrated no behaviors. He required supervision with one person physical assistance with transfers, had impairment one side to lower extremity, used a wheelchair and had limb prosthesis. Resident #50 required partial to moderate assistance with showering and bathing, lower body dressing below the waist, getting in and out of shower, and transferring from chair to wheelchair. He required substantial to maximal assistance with taking off and putting on footwear. Review of Resident #50's care plan dated 10/23/23 revealed a plan of care was in place for resident being independent on meeting emotional, intellectual, and social needs, however, at this time he is dependent on staff to meet some physical needs due to limitations. Interventions included, in part, to converse with resident while providing care, ensure adaptive equipment that the resident needs is provided and present and functional. Additionally, a plan of care was in place for at risk for falls related to gait and balance problems with an interventions to include, in part, call light within reach and requires a prompt response to all requests for assistance. Review of the camera footage timeline on an incident report dated 05/17/24 revealed the following: 10:42 AM Resident #50 entered the shower room. NA #8 followed Resident #50 and entered the shower room. 10:46 AM Nurse Aide #8 exited the shower room 10:48 AM Nurse Aide #8 reentered the shower room 10:49 AM Nurse Aide #8 exited the shower room	F 689	All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Social Worker, or Designee, will educate all nursing staff by 8/5/2024 on the importance of staying with residents for the entire Activities of Daily Living (ADLs) process to ensure resident safety and quality of care is being provided. After 8/5/2024 newly hired staff will be educated by the LNHA, DON, or Designee during their new hire employee orientation. Beginning 7/27/2024, the LNHA, DON, Social Worker, or Designee, will interview 3 alert & oriented dependent residents per week x 12 weeks to ensure they feel safe when in the shower room while utilizing a shower chair, to ensure they are not left alone in the shower room during their showers, and to ensure their call lights are being answered in a timely manner. If a resident has a concern the Social Worker or Designee will write a grievance regarding the concern, investigate the concern, and implement an intervention to rectify the grievance. The LNHA, DON, or Designee will ensure if a staff member is involved in the concern the staff member will be re-educated and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the audits will be	

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F 689	Continued From page 103 11:00 Call light in shower room sounds 11:16 AM Nurse Aide #8 entered the shower room 11:20 AM Nurse Aide #8 and Resident #50 exited shower room and went to Nurse #9 and were telling her something. An interview with Resident #50 on 06/14/24 at 1:00 PM revealed on 05/17/24, he was left unattended in the shower for over 15 minutes. He stated he was on the smoking porch and stated he wanted to get a shower early on this day because he had family coming. Resident #50 stated Nurse Aide (NA) #8 said he was not on her assignment, but that she would get him started in the shower. Resident #50 stated NA #8 took him to the shower and assisted with transferring him to the shower chair from his wheelchair and assisted him with getting undressed, removed his prosthetic leg and turned the shower on. Resident #50 stated he proceeded to bathe himself and washed his hair. He used the call bell to alert for help when he was done. He stated no one came after a few minutes so he turned the water again to keep himself warm and washed himself again while waiting for someone to answer the call bell. He stated he then started to yell for someone to come and help him, but no one came. Resident #50 stated the shower chair did not have wheels like his wheelchair so he was not able to move it easily, but he was able to reach a towel and dry off and reached his prosthetic leg and put it on. He stated he continued to yell, but still no one came. Resident #50 stated he then attempted to transfer himself from the shower chair to the wheelchair but he banged his leg and was not able to transfer himself safely. Resident #50 stated after about 15 minutes, NA #8 finally came	F 689	reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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back and helped him get out of the shower chair and transferred him to his wheelchair.

An interview was conducted NA #8 on 06/14/24 at 2:35 PM. NA #8 reported she was on the smoking porch with Resident #50, and he reported he wanted a shower. He stated his aides from the 100 hall were busy so she told him she would get him in the shower. NA #8 stated she was assigned to the 200 hall, but she helped transfer Resident #50 to a shower chair from his wheelchair and assisted with removing his clothes and his prosthetic leg. She then turned on the water and he began to take his shower. NA #8 stated that she and Nurse #7, who was also assigned to the 200 hall, told Nurse #9 who was assigned to the 100 hall that they were going to the store to get soap which was located across the street and only minutes away. NA #8 stated they were back within 15 minutes or less and when they came back, they saw the shower light going off and Nurse #9 was sitting at the computer at the nursing station. NA #8 stated she went into the shower room and saw Resident #50 was still in the shower. She assisted him with getting dressed and brought him out of the shower room. She stated Resident #50 wanted to know why his aides left him in the shower room. NA #8 stated she was told by the Director of Nursing after it all happened that if she could not stay with a resident while in the shower, then do not give the shower to the resident and to leave it to the assigned nurse aides to do the shower. NA #8 stated she should not have left Resident #50 alone in the shower because no resident should be left alone while they were getting a shower for safety reasons. She stated Resident #50 could wash and dress himself, but he needed assistance with dressing, and he

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needed assistance pulling himself out of the shower chair to his wheelchair. NA #8 added, Resident #50 needed someone there to get him out of the shower and he was not safe to be left alone.

An interview was conducted with Nurse #7 on 06/13/24 at 11:45 AM. Nurse #7, who was not assigned to Resident #50, reported on 05/17/24, Resident #50 was out on the smoking porch and stated he had family coming in to see him today and he wanted a shower and NA #8 said she would give him one. NA #8 assisted Resident #50 in the shower. She stated after he was in the shower, she and NA #8 told Nurse #9 that they were leaving the facility to go to the store across the street to get soap and that Resident #50 was in the shower and for her to let his aides know so they could get him out. Nurse #7 reported they were at store for about 15 minutes and when they came back, the call light was on to the shower room and Nurse #9 was sitting at the nurse's station not answering the light. Nurse #7 stated NA #8 went to the shower room to assist Resident #50 out of the shower. Nurse #7 stated Nurse #9 did not tell the aides that were assigned to Resident #50 that he was in the shower and she did not answer the light when it rang. Nurse #7 stated anytime any resident was getting a shower, the nursing staff was to supervise the resident while in the shower to prevent any accidents and she should have made sure someone was supervising Resident #50 before she left for the store.

An interview was conducted with Nurse #9 via phone on 06/13/24 at 2:19 PM. Nurse #9 reported she was the nurse assigned to the 100 hall on 05/17/24 where Resident #50 resided.

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She stated Resident #50 was upset about being left in the shower room and that no one was answering the call light to assist him. She stated Resident #50 told her that NA #8 had put him in the shower and left. Nurse #9 stated she had learned from NA #8 that she and Nurse #7 left the building to go to the store, but it was not until they returned. Nurse #9 stated neither NA #8 nor Nurse #7 reported to her that Resident #50 was in the shower or that they were going to the store. Nurse #9 stated she did not recall hearing the call light going off.

An interview was conducted with NA #4 via phone on 06/18/24 at 10:39 AM. NA #4 reported she had worked at the facility as agency nurse aide for about 8 weeks. She stated she was assigned to Resident #50 on the 100 hall on 05/17/24. NA #4 reported she did not what had actually happened on 05/17/24 but was told someone put Resident #50 in the shower, but they did not inform her or NA #5 who was also assigned to Resident #50. NA #4 reported Resident #50 and Nurse #9 approached her and NA #5 while they were doing resident care for another resident and Resident #50 was yelling at us for leaving him in the shower, but they had no idea he was even in the shower and did not hear the call light because they were in another room down another hall. NA #4 stated whenever she gave Resident #50 a shower, she would assist him getting undressed, removing his prosthetic, and transferring him from the wheelchair to the shower chair. She stated she would provide privacy while he would bathe himself, but that in order to provide safety for the resident, she would not leave the shower area and leave the resident unattended. She stated no resident should be left in the shower area alone because they could fall and hurt

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F 689	Continued From page 107 themselves. An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 11:00 AM. The DON reported that a nursing staff member should always be with a resident whenever they were getting a shower. The DON stated she did not know NA #8 and Nurse #7 left the building and it was not okay for them to leave without telling anyone. She stated her expectation of nursing staff was that residents should not be left in the shower alone because of the potential for an accident. The DON added Resident #50 had a mobility risk due to his impairment and he required supervision while in the shower.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		7/27/24

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F 692	Continued From page 108 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Registered Dietitian and Facility Physician interviews, the facility failed to obtain physician ordered weekly weights for 4 of 6 residents reviewed for nutrition and wound care evaluation (Resident #36, Resident #38, Resident #219, Resident #52) and failed to address a Registered Dietitian recommendation for a medication to stimulate appetite for 2 of 6 residents reviewed for nutrition (Resident #36, Resident #38). Findings included: 1. Resident # 36 was admitted on 2/8/24 with diagnoses which included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and diabetes. Resident # 36's electronic health record included a 2/8/24 physician order for weight on admission then weekly for 3 weeks (4 weights total); then monthly or as specified by the physician. Resident # 36's weight record contained the following: 2/9/2024 10:13 AM 118.7 pounds (lbs.) 2/16/2024 No weight recorded. 2/23/2024 No weight recorded. 3/3/2024 7:06 PM 121.0 lbs. A 3/12/24 Registered Dietitian (RD) note indicated Resident #36 was reviewed. Resident # 36 consumed 25-100 percent of a carbohydrate-controlled diet. RD recommended providing supervision and cueing with meals and	F 692	The facility failed to obtain physician ordered weekly weights for 4 of 6 residents reviewed for nutrition and wound care evaluation (Resident #36, Resident #38, Resident #219, Resident #52) and failed to address a Registered Dietitian recommendation for a medication to stimulate appetite for 2 of 6 residents reviewed for nutrition (Resident #36, Resident #38). Resident #36 was admitted on 2/8/2024 with an admission weight of 118.7lbs. It was identified that weekly weights were not obtained for Resident #36. However, his next monthly weight on 3/3/2024 was 121.0lbs. The next monthly weight showed a weight loss of 23.0lbs on 4/5/2024. However, it was identified in an on-site note by the Primary Care Provider (PCP) who was also the active Medical Director of the facility that the weight had not changed, which was inaccurate. On 4/9/2024, the Registered Dietitian noted that the weight on 4/5/2024 was 98.0lbs and also showed a 19% weight loss in one month. The Registered Dietitian listed recommendations, however, did not note if the recommendations were provided to the PCP. As of 7/31/2024, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) identified that Resident #36 is still undergoing weight loss. The DON has implemented weekly weights to monitor Resident #36's nutritional status.	

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F 692	Continued From page 109 a fortified foods diet. A physician order dated 4/4/24 indicated weekly weights for weight monitoring and regular fortified food diet. A 4/9/2024 Registered Dietitian (RD) note indicated Resident #36 was reviewed for weight loss. The note stated resident's current weight on 4/5/24 was 98 lbs. Resident #36's weight was 121 lbs. on 3/3/24 which was a weight loss of 19 percent in 1 month. The RD indicated Resident #36 consumed 0-75% of a mechanical soft diet with supervision. The following recommendations were made obtain a reweigh to verify current weight, weekly weight x 4 weeks, medication to increase appetite and add protein supplement three times per day. Resident #36's weight record indicated the following weights: 4/5/2024 98.0 Lbs. 4/12/2024 No weight recorded. 4/19/2024 No weight recorded. 4/20/2024 98.2 Lbs. 4/27/2024 No weight recorded. 5/4/2024 106.4 Lbs. 5/11/2024 No weight recorded. 5/18/2024 No weight recorded. 5/25/2024 No weight recorded. 6/1/2024 No weight recorded. 6/9/2024 No weight recorded. A 5/7/2024 Registered Dietitian note stated in part Resident # 36's weights were reviewed with a gain of 8.5% in 1 month and a loss of 10.3% in 3 months. The note did not indicate a reason for the weight fluctuations.	F 692	Resident #38 was admitted on 8/14/2020 with an admission weight of 130.0lbs. It was identified that on 8/19/2020, Resident #38 weighed 135.5lbs. It was identified that Resident #38 has had weight fluctuations from the time of admission to current. As of 4/23/2024, the Registered Dietitian listed recommendations, however, did not note if the recommendations were provided to the PCP. As of 7/31/2024, LNHA and DON identified that Resident #38 is still undergoing weight loss. The DON has implemented weekly weights to monitor Resident #38's nutritional status. Resident #219 was admitted on 5/22/2024 with an admission weight of 191.8lbs. On 6/25/2024 Resident #219 weighed 176.0lbs. It was identified that weekly weights have not been obtained upon admission and Resident #219 has experienced weight loss. As of 6/27/2024, the Registered Dietitian listed recommendations, however, did not note if the recommendations were provided to the PCP. As of 7/31/2024, the LNHA and DON identified that Resident #219 is still undergoing weight loss. The DON has implemented weekly weights to monitor Resident #219's nutritional status. Resident #219 frequently leaves the facility on Therapeutic Leave and is non-compliant with medications and health care routine while on Therapeutic Leave. Resident #52 was admitted on 5/2/2024	

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F 692	Continued From page 110 Resident # 36's care plan revised on 5/14/24 indicated a nutrition at risk problem related to weight loss with interventions to obtain weights per orders, fortified foods, and monitor intake and record. Resident # 36's quarterly Minimum Data Set (MDS) assessment dated 5/15/24 revealed resident had a severe cognitive impairment, weight of 106 lbs. and was on a physician prescribed weight gain program. An interview was conducted on 6/12/24 at 2:15 PM with the Agency Director of Nursing (DON). The DON stated weights were not consistently obtained. The DON stated the facility required a better system for obtaining weights and addressing nutritional recommendations. The DON stated she expected staff to obtain weights on admission and weekly for 3 weeks following admission. The DON further indicated she expected physician ordered weights would be obtained. Without the monitoring of weights, the RD and physician are not able to evaluate the root cause of weight changes in the residents. An interview was conducted on 6/12/24 at 2:45 PM with the Registered Dietician (RD). The RD stated weights were supposed to be obtained within the first ten days of the month and that was not being done. The RD stated she informed the Administrator and DON several times over the past 3 months that resident weights were a problem, were not being obtained and this had not improved. The RD indicated Resident # 36's weights were not obtained weekly on admission and as ordered. The RD stated weights were necessary to make recommendations, evaluate	F 692	with an admission weight of 193.0lbs. On 6/14/2024 Resident #52 weighed 192.6lbs. It was identified that weekly weights have not been obtained upon admission and Resident #52 has experienced weight loss. As of 7/18/2024, the Registered Dietitian listed recommendations, however, did not note if the recommendations were provided to the PCP. As of 7/31/2024, the LNHA and DON identified that Resident #52 is still undergoing weight loss. The DON has implemented weekly weights to monitor Resident #52's nutritional status. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The DON or Designee, reviewed all weight orders on 7/26/2024 to ensure the staff has a correct list of residents who require weekly and monthly weights. The DON or Designee will educate all nursing staff by 8/5/2024 on the importance of following provider orders in regard to obtaining weights and to ensure those identified residents nutrition statuses are being monitored appropriately per recommendations from the Registered Dietitian. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit ordered weekly	

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F 692	Continued From page 111 the resident's nutritional needs and evaluate current interventions. Without accurate weights and obtaining weekly weights as ordered, the RD stated it was difficult to determine the cause of Resident # 36's weight changes. A follow up interview was conducted with the Director of Nursing (DON) on 6/14/24 at 4:10 PM. The DON stated weights were not obtained timely and accurately. The DON stated she was hired through an agency a few months ago and had not implemented a process for obtaining weights yet but indicated it was an important part of the resident's care and was necessary to evaluate the resident's condition. An interview was conducted with the Facility Physician on 6/18/24 at 1:24 PM. The Facility Physician stated she started in the position on 6/7/24 and indicated monitoring of weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Facility Physician further stated weights were to be obtained as ordered and the recommendations made by the Registered Dietitian should be evaluated and addressed. The Facility Physician stated Resident #36's weights should have been obtained as ordered and the Registered Dietitian recommendations should have been addressed. Attempts were made to interview the previous Physician who was in the position at the facility until 6/6/24. Messages were left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received. Attempts were made to interview the previous Nurse Practitioner (NP) who was in the position at	F 692	weights x 12 weeks to ensure provider orders are being followed and any change in weight is reported to the provider immediately. Any missed weekly weights will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the DON or Designee will audit weekly Registered Dietitian recommendations x 12 weeks to ensure the recommendations are being addressed and followed up on. Any missed Registered Dietitian recommendations will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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the facility until 6/6/24. Messages were left on 6/12/24 at 3:36 PM and 6/13/24 at 3:07 PM with no return call received.

2. Resident #38 was admitted on 8/14/20 with diagnosis which included stroke and dementia.

Resident # 38's care plan dated 12/15/23 indicated a problem of at nutritional risk for weight loss with the following interventions included physician or Nurse Practitioner to evaluate for failure to thrive, fortified foods, protein supplement and consult with physician regarding order for vitamin or other appetite stimulant and RD consult.

Resident # 38's weight record indicated:

12/30/23 91.2 pounds (lbs.).
1/8/2024 89.0 lbs.
1/21/2024 102.0 lbs.
2/5/2024 105.0 lbs.
3/3/2024 89.5 lbs.

Resident # 38's physician orders indicated an order for regular diet with fortified foods.

A 3/12/24 Registered Dietitian progress note indicated Resident # 38 was reviewed for weight loss trend. A weight of 113.5 Lbs. was recorded on 9/6/23 which indicated a 21.3 percent weight loss over 6 months. Recommendation was made to obtain a reweigh due to weight loss and obtain weekly weight for 4 weeks.

Resident # 38's physician orders indicated a 3/18/24 order for weekly weights for weight monitoring until 04/15/2024.

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Resident # 38's weight record indicated:

3/19/2024 89.0 lbs.
3/26/24 no weight recorded.
4/5/2024 93.0 lbs.
4/12/24 no weight recorded.
4/20/2024 83.0 lbs.

Resident # 38's 4/22/24 quarterly Minimum Data Set (MDS) indicated a weight of 83 lbs. and weight loss of 5 percent or more in the last month or loss of 10 percent in the last 6 months.

An RD progress note dated 4/23/2024 indicated Resident # 38 was reviewed for weight loss. Current weight 4/20/24 83 lbs. A weight of 113 lbs. on 10/11/23 indicated a loss of 18.6 percent over 3 months, and a loss of 26.5 percent over 6 months. Resident # 38 consumed 0-50 percent of a regular fortified foods diet and received a protein supplement. Recommendations included: medication to help increase appetite, obtain weekly weights for 4 weeks and evaluate for failure to thrive and protein calorie malnutrition due to weight loss and decreased appetite. The RD did not indicate a root cause analysis of Resident # 38's weight loss.

Resident # 38's physician orders revealed no order dated 4/23/24 or later was entered for weekly weights.

Resident # 38's physician orders revealed no order dated 4/23/24 for a medication to help increase appetite.

A physician note dated 5/3/24 indicated Resident # 38's weight loss and the 4/23/24 Registered Dietitian recommendation for medication to

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increase appetite were not addressed.

Resident # 38's weight record indicated:

5/2/2024 92.0 lbs.
5/9/24 no weight recorded.
5/17/24 no weight recorded.
5/24/24 no weight recorded.

Review of a Nurse Practitioner progress note dated 5/20/24 indicated resident's weight and the 4/23/24 Registered Dietitian recommendation for medication to increase appetite were not addressed.

Resident # 38's electronic health record included a Registered Dietitian progress note dated 5/30/2024. The progress note indicated Resident # 38 was reviewed for weight loss trend. Current weight 5/2/24 92 lbs.
Weight on 11/2/23 was 112 lbs. which indicated a 12.3 lbs. weight loss in 3 months and 17.8 percent loss over 6 months. Recommendations included: medication to help increase appetite and physician evaluation for failure to thrive or protein calorie malnutrition diagnosis.

Resident #38's physician orders revealed no order dated 5/30/24 or later was entered for a medication to help increase appetite.

Resident #38's electronic health record revealed no physician progress note addressing the 5/30/24 Registered Dietitian recommendation for a medication to increase appetite or evaluation for diagnosis of failure to thrive or protein calorie malnutrition.

Attempts were made to interview the previous

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Physician who was Medical Director until 6/6/24. Messages were left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received.

Attempts were made to interview the previous Nurse Practitioner (NP) who was employed at the facility until 6/6/24. Messages were left on 6/12/24 at 3:36 PM and 6/13/24 at 3:07 PM with no return call received.

An interview was conducted on 6/12/24 at 2:45 PM with the Registered Dietitian (RD). The RD stated weights were to be obtained within the first ten days of the month and that was not being done. The RD indicated she had a concern regarding the accuracy of the weights and reweights were not obtained when there was a weight change. The RD stated she informed the Administrator and the Director of Nursing several times over the past 3 months that resident weights were not obtained and there was no improvement. The RD indicated Resident #38's weights were not obtained as ordered or as recommended and this made it difficult to make recommendations, evaluate the resident's nutritional needs and evaluate current interventions. The RD stated that the nutritional recommendations were not addressed for Resident #38.

An interview was conducted with Unit Manager #2 on 06/14/24 at 2:00PM. Unit Manager #2 stated she was responsible for ensuring the weekly and monthly weights were obtained. She stated the order for weekly weights was entered into the computer system for all new admissions. She stated when she selected the order type, she did not select "Medication Administration Record (MAR),", but instead selected "other orders, no

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documentation required." She stated by selecting the other orders option, the order would not carry over to the MAR to inform the nursing staff that a weekly weight was due. She stated the weekly weight order also did not populate on the weekly weight order report and that was why the weights were not done. Unit Manager #2 stated she gave a list of weights that were needed to the Nursing Assistants (NAs), but she did not follow up with them to ensure they were obtained.

A follow up interview was conducted with the Agency Director of Nursing (DON) on 6/14/24 at 4:10 PM. The DON stated weights were not being done due to a breakdown in the process. The DON stated she expected weights would be obtained timely and accurately. The DON further indicated she was hired through an agency, had only been in the position of DON at the facility for a few months and had not yet implemented a process to obtain weights. The DON indicated nutrition was an important part of the resident's care and weights were necessary to evaluate the resident's condition.

An interview was conducted with the Facility Physician on 6/18/24 at 1:24 PM. The Facility Physician stated she had only been in the position since 6/7/24. The Facility Physician stated obtaining weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Facility Physician further indicated that weights were to be obtained as ordered and the recommendations made by the Registered Dietitian should be evaluated and addressed. The Facility Physician stated Resident #38's weight changes and the recommendation for a medication to stimulate appetite should have been evaluated and addressed.

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3. Resident #219 was admitted to the facility on 05/22/24 with diagnosis including cellulitis of the left lower limb and diabetes.

A physician's order dated 05/22/24 for Resident #219 revealed to obtain weight on admission then weekly for three weeks, then monthly or as specified by the physician.

A physician's order dated 05/28/24 for Resident #219 revealed to obtain weekly weights for nutrition and wound evaluation.

The Minimum Data Set (MDS) admission assessment dated 05/28/24 revealed Resident #219 was cognitively intact. She received wound care and a therapeutic diet. The weight was 191.8 lbs. (pounds). There was no weight loss or gain. The care area assessment indicated to initiate a care plan with interventions for nutritional status.

Review of Resident #219's electronic medical record from admission on 05/22/24 through 06/19/24 revealed an admission weight recorded on 05/22/24. The weight was 191.8 lbs. (pounds). There were no other weights recorded.

During an interview on 06/14/24 at 10:23 AM Nurse Aide #3 stated she recently started working in the facility and was the assigned Nurse Aide for Resident #219. She stated she was given a list at the beginning of the month of residents that needed monthly weights. She stated if a weekly or daily weight was needed the nurse would let her know. She stated she had not been told to obtain Resident #219's weight. She indicated she had not received a list of residents who needed

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weights so far this month.

During an interview on 06/14/24 at 10:53 AM Nurse #6 stated she was routinely assigned to the 400 hall and to Resident #219. She stated the nurse aides obtained monthly weights and the weights were given to the nurse to enter into the electronic medical record. She stated she was not aware Resident #219 had an order for weekly weights because nothing populated in the electronic medical record to notify her that a weekly weight was needed for Resident #219.

During an interview on 06/14/24 at 11:30 AM Nurse Aide #4 stated the unit manager gave them a list of names each month of residents that needed weights. She stated they received the list of names at different times during the month. At times she would get the list of names at the beginning of the month, other times she received the list of names for weights later in the month. She stated she didn't know which residents received weekly weights and the nurse would inform her if a weight was needed. She stated when weights were obtained each month the weights were given to the assigned nurse and the nurse entered the weight into the electronic medical record.

During an interview on 06/14/24 at 11:30 AM Nurse Aide #5 stated the unit manager gave them a list of names each month of residents that needed weights. She stated she didn't know which residents received weekly weights and the nurse would inform her if a weight was needed. She indicated when weights were obtained each month the weights were given to the assigned nurse and the nurse entered the weight into the electronic medical record. She stated she didn't

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typically work the 400 hall and was not aware Resident #219 had orders for weekly weights.

During an interview on 06/14/24 at 12:30 PM the Registered Dietician stated there had been issues with getting weights. She stated the Director of Nursing, and the Administrator were aware of the issue, and it was being discussed in their Quality Assurance meetings. She reported that Resident #219 was admitted on 05/22/24 with cellulitis and an abscess on the groin. She received daily wound care to the area and received nutritional supplements three times a day. She reported Resident#219's BMI (body mass index) was elevated, and the weekly weights were ordered to evaluate her nutrition for wound assessments. She stated she was aware the weekly weights were not getting done and had reported this to Administration. She expected weights to be obtained according to the physician's order.

During an interview on 06/14/24 at 1:18 PM the Wound Nurse indicated she was not aware Resident #219 had an order for weekly weights to assess her nutritional needs for wound evaluation. She stated Resident #219 was followed by the wound care physician weekly in the facility and the wound was improving. She indicated the weekly weight order was not on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) and therefore she was not aware of the order.

During an interview on 06/14/28 at 2:00 PM Unit Manager #2 indicated she had not followed up on weights. She stated she printed a list of names each month and gave the list to the nurse aides. She stated she did not follow up to ensure weights were obtained and reported to the nurses

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each month because the Registered Dietician reviewed weights. She indicated that she had not given the list of resident names to the nurse aides to obtain weights for the current month and she was not aware that Resident #219 had orders for weekly weights.

During an interview on 06/14/24 at 4:08 PM the Director of Nursing (DON) stated monthly weights were to be done by the 5th of each month and weekly weights should be obtained on the first day of the week. She indicted she was aware that obtaining weights was an issue. She reported staff responsible for obtaining weights had developed bad habits and there had been no accountability. She stated more work was needed and staff education would be provided.

A phone interview was conducted with the Physician on 6/18/24 at 1:24 PM. The Physician stated monitoring of weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Physician indicated that weights were to be obtained as ordered and the recommendations made by the Registered Dietitian should be evaluated and addressed.

4. Resident #52 was admitted to the facility on 05/02/24.

A physician's order dated 05/02/24 for Resident #52 revealed to obtain weights on admission then weekly for three weeks, then monthly or as specified by the physician.

Review of Resident #52's electronic medical record from admission on 05/02/24 through 06/14/24 revealed an admission weight recorded

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on 05/02/24 which was 192.6 pounds. There were no other weights recorded.

The Minimum Data Set admission assessment dated 05/09/24 revealed Resident #52 was severely cognitively impaired and required set up or clean up assistance with eating. Resident #52 was on a regular diet and her weight was recorded as 193 pounds. There was no weight loss or gain. The care area assessment indicated to initiate a care plan with interventions for nutritional status.

An interview was conducted with the Registered Dietitian (RD) on 06/12/24 at 2:45 PM. The RD indicated Resident #52's weights were not obtained weekly as ordered. The RD stated weights were necessary to make recommendations, evaluate the resident's nutritional needs and evaluate current interventions. The RD stated it was difficult to determine the cause of Resident # 52's weight changes without obtaining weekly weights as ordered. The RD stated she was aware the weekly weights were not getting done and had reported it to Administration.

An interview was conducted with Nurse #7 on 06/13/24 at 11:45 AM. Nurse #7 reported the nurse aides obtained the monthly weights and the weights were given to the nurse to enter into the electronic medical record. She stated she was not aware Resident #52 had an order for weekly weights because nothing populated in the electronic medical record to notify her that a weekly weight was needed. She stated any newly admitted residents should have weekly weights for one month and then changed to monthly thereafter.

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An interview was conducted with Nurse Aide (NA) #8 on 06/14/24 at 1:11 PM. NA #8 reported she was usually given a list at the beginning of the month of residents who needed a monthly weight. NA #8 added, if a nurse needed a weekly or daily weight she would let her know. NA #8 stated she had not been told to obtain Resident #52's weight and had not received a list of residents who needed monthly weights as of this time. She stated when the weights were obtained she would give them to the assigned Nurse and she believed they would enter them in the electronic medical record.

An interview was conducted with Unit Manager (UM) #2 on 06/14/24 at 2:00 PM. UM #2 stated she was responsible for ensuring the weekly and monthly weights were obtained. She stated with new admissions, part of the admission process was to initiate batch orders for weekly weights. She stated the order for the weekly weights that she entered into the electronic record was not entered correctly to populate to the medication administration record to alert nursing staff that a weight was due. UM #2 added due to this error, the weekly weight order also did not populate on to her weekly weight report so she was not aware that Resident #52 needed weekly weights for 3 weeks and that was why they were not done.

An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 4:10 PM. The DON stated weights were not obtained timely and accurately. The DON stated she was hired through an agency a few months ago and had not implemented a process for obtaining weights yet but indicated it was an important part of the resident's care and was necessary to evaluate

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F 692	Continued From page 123 the resident's condition. An interview was conducted with the Facility Physician on 06/18/24 at 1:24 PM. The Facility Physician stated she started in the position on 06/07/24 and indicated monitoring of weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Facility Physician further stated weights were to be obtained as ordered.	F 692		
F 697 SS=K	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, Consultant Pharmacist, and Physician interview, the facility failed to provide effective pain management and manage symptoms of withdraw for 2 of 10 residents (Resident #51 and Resident #46) reviewed for pain management. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not available to administer and resulted in a total of 21 doses of the prescribed medication not administered from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain at up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) per her request on 5/12/24 in the middle of the	F 697	The facility failed to provide effective pain management and manage symptoms of withdraw for 2 of 10 residents (Resident #51 and Resident #46) reviewed for pain management. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not available to administer and resulted in a total of 21 doses of the prescribed medication not administered from 5/8/2024 through 5/13/2024. Resident #51 had complaints of constant pain at up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to	7/27/24

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F 697	Continued From page 124 night where she was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED that evening per her request for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not available to administer on 5/10/24 and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in increased pain at a sustained 8-9 pain level, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Immediate Jeopardy began when the facility failed to provide effective pain management for Resident #51 on 5/9/24 resulting in a pain level of 10 out of 10, and for Resident #46 on 5/12/24 when the resident had increased pain and difficulty sleeping. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Findings included: Gabapentin is an anticonvulsant medication prescribed for seizures and nerve pain. Manufacturer instructions indicated gabapentin	F 697	the Emergency Department (ED) per her request on 5/12/2024 in the middle of the night where she was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/2024 and returned to the ED that evening per her request for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not available to administer on 5/10/2024 and Resident #46 missed 14 doses of the medication from 5/10/2024 through 5/17/2024 resulting in increased pain at a sustained 8-9 pain level, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Immediate Jeopardy began when the facility failed to provide effective pain management for Resident #51 on 5/9/24 resulting in a pain level of 10 out of 10, and for Resident #46 on 5/12/24 when the resident had increased pain and difficulty sleeping. Immediate Jeopardy was	

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caused physical dependence and stopping the medication results in withdrawal symptoms. Within 12 hours after stopping gabapentin, withdrawal symptoms may start and may be severe. Withdrawal symptoms include nausea, insomnia, anxiety, tremors, body aches, increased pain, hallucinations and seizures.

1. Resident #51 was admitted on 10/19/23 with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities).

Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain.

Review of Resident #51's physician orders revealed an order dated 4/10/24 for methadone 5 mg 2 times per day for pain and an order dated 4/18/24 for baclofen 20 mg 3 times per day for muscle spasms.

Review of Resident #51's care plan revealed a focus dated 11/7/23 of pain due to chronic back pain. The goal indicated resident's pain will be relieved with use of pain medications. Interventions included provide/ administer pain medications as ordered, monitor for complaint of pain and report the need for further interventions.

Review of Resident #51's quarterly Minimum Data Set (MDS) dated 4/4/24 indicated resident was cognitively intact The MDS assessment was coded as received scheduled and as needed pain medication. The pain interview was not assessed.

removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal.

Upon identification of the severity of the alleged deficient practices, the Licensed Nursing Home Administrator (LNHA) wrote the Immediate Jeopardy Removal Plan and submitted the Removal Plan for approval. The Immediate Jeopardy was removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The LNHA terminated the agency Director of Nursing (DON) during extended survey on 6/19/2024. The LNHA hired an experienced non-contractual DON on 6/19/2024 to ensure future compliance. The facility has also hired nursing staff including RNs and LPNs to ensure future compliance.

The DON or Designee will review all Medication Administrator Records (MARs) for residents receiving pain medications to ensure there are no missing doses. All missing doses will be reported to the provider and documentation will follow to ensure compliance by 8/5/2024.

The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the steps to follow when a medication is not in stock, as well as proper documentation that describes all the steps that were taken to ensure the resident receives their medications as ordered to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the

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F 697	Continued From page 126 The pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on 4/25/24. The pharmacy record indicated the 92 gabapentin pills from the 4/25/24 supply for Resident #51 were returned to the pharmacy while Resident #51 was in the hospital from 5/5/24 through 5/8/24. The hospital discharge summary dated 5/8/24 indicated Resident #51 was hospitalized from 5/5/24 through the morning of 5/8/24. The hospital discharge summary indicated the order for gabapentin for Resident #51 was unchanged when she returned on 5/8/24. The May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and the documentation of a "9" indicated to see the nursing notes. This MAR did not include routine monitoring of pain using a 0-10 pain scale rating. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/8/24 - The MAR for 5:00 PM indicated Nurse #8 documented a "9" and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy. - The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note. 5/9/24 - The MAR for 9:00 AM indicated Nurse #9 documented a "9" and there was no	F 697	DON or Designee during their new hire employee orientation. The DON or Designee will educate all nurses by 8/5/2024 on the importance of completing pain assessments daily for all residents that are receiving pain medications to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit pain medication administrations 5 times per week for 12 weeks to ensure all pain medications are given as ordered. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the DON or Designee will interview 3 residents per week x 12 weeks to ensure his/her pain is being managed effectively. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Any pain that a resident expresses that is not being managed effectively will be reported to the provider. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI)	

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F 697	Continued From page 127 corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note. A pain assessment dated 5/9/24 was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse # 8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 reported increased pain when she did not receive her gabapentin. Nurse # 8 stated Resident # 51 was frustrated about not receiving the medication gabapentin as order. Nurse #8 stated she did not report Resident #51's concerns about not receiving the medication gabapentin to administration and did not have an explanation for why she did not report the concerns. A nursing progress note written by Nurse #8 on 5/10/24 at 3:24 AM indicated Resident #51 reported her legs were numb. The note indicated	F 697	Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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the writer (Nurse #8) informed Resident #51 there were no interventions for this and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room.

The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/10/24
- The MAR for 9:00 AM indicated Nurse # 9 documented a "9" and there was no corresponding nursing note.
- The MAR for 12:00 PM indicated Nurse # 9 documented a "9" and there was no corresponding nursing note.
- The MAR for 5:00 PM indicated Nurse # 9 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse # 13 documented a "9" and the corresponding administration record note at 10:12 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.

An interview was conducted via phone with Nurse # 9 on 6/13/24 at 2:15 PM. Nurse # 9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse # 9 stated Resident # 51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse # 9 revealed she documented "9" which indicated the medication was not available for the doses. Nurse # 9 stated she did not attempt to obtain medication for Resident #51 and the resident reported pain in her legs. Nurse #9 indicated it was normal for Resident #51 to refuse her shower.

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An interview was conducted via phone with Nurse #13 on 6/27/24 at 12:50 PM. Nurse #13 revealed she was assigned to Resident #51 on 5/10/24 from 7:00 PM to 7:00 AM. Nurse #13 indicated the ordered medication gabapentin 800 mg was unavailable for the scheduled dose at 9:00 PM. Nurse #13 recalled that Resident #51 normally did not complain of pain other than discomfort from her suprapubic catheter (a tube inserted through the abdomen to drain urine from the bladder).

The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/11/24
- The MAR for 9:00 AM indicated Unit Manager #1 documented a "9" and there was no corresponding nursing note.
- The MAR for 12:00 PM indicated Unit Manager #1 documented a "9" and there was no corresponding nursing note.
- The MAR for 5:00 PM indicated Nurse #14 documented a "9" and the corresponding progress note on 5/11/24 at 4:15 PM indicated gabapentin 800 mg was pending from the pharmacy and the nurse pass on information to next shift to follow up.
- The MAR for 9:00 PM indicated Nurse #2 documented a "9" and there was no corresponding nursing note.

An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not

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recall if she made any attempt to obtain the medication for Resident #51 and did not assess Resident #51 for pain. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks and prior to that she worked the 7:00 PM to 7:00 AM shift. Unit Manager #1 stated she was aware that Resident #51 ran out of gabapentin and required emergency room evaluation due to increased pain but did not recall any further details of the situation. Unit Manager #1 stated she did not recall if she had been involved in obtaining the medication gabapentin for Resident #51.

A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to the emergency room. Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal.

An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated for a chief complaint that the facility had been out of her gabapentin for a couple of days and now she was experiencing full body cramps. The ED Summary stated Resident #51 presented to the ED on 5/12/24 at 4:22 AM and reported she had not had her gabapentin and thought she was in gabapentin withdrawal. While in the ED, at 4:43 AM on 5/12/24 Resident #51 was administered gabapentin 800 mg. The discharge instructions were to restart gabapentin 800 mg 4 times per day, to follow up with her primary care physician and to not stop taking prescription medication for pain suddenly. Resident #51 was discharged back to the facility on 5/12/24 at 6:11 AM.

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An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM. Nurse #2 stated she was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital during the night on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Nurse #2 stated it looked like Resident #51 was exhibiting withdrawal symptoms. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider and sent Resident #51 to the hospital. Nurse #2 stated medications were frequently not available in the facility, and she had been told by other nurses, although she was not able to recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done about the medications not being available.

A progress note written by Nurse #14 on 5/12/24 at 10:09 AM indicated Resident #51 returned from the hospital at approximately 8:00 AM. Unit Manager #1 was made aware on 5/11/24 that Resident #51's gabapentin was not available in the facility and the resident was sent to the emergency room during the night on 5/12/24 to obtain it.

The MAR for 5/12/24 revealed Nurse #14 inaccurately documented a "6" for the 9:00 AM, 12:00 PM, and 5:00 PM doses of Resident #51's gabapentin which indicated the resident was in the hospital. (Resident #51 returned from the ED

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on 5/12/24 at approximately 8:00 AM [per Nurse #14's progress note] and the next scheduled dose of gabapentin was due at 9:00 AM).

Attempts were made via phone to interview Nurse #14, a nurse that worked through an agency as needed. Messages left on 6/13/24 and 6/14/24 with no return call received.

An ED Summary dated 5/12/24 at 8:50 PM indicated Resident #51 presented with muscle spasms and reported she was unable to get her gabapentin prescription refilled at the nursing facility and was having breakthrough pain. The Medication Administration Record for the ED indicated Resident #51 was administered gabapentin 800 mg on 5/12/24 at 9:12 PM. Resident #51 was discharged back to the facility on 5/12/24 at 9:41 PM with instructions to continue with gabapentin 800 mg 4 times per day.

A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening "muscle spasms all over" and requested to go to the emergency department. 911 was called for transfer to the emergency room. Resident #51 returned to the facility having received Gabapentin at the emergency room. Resident #51 told the emergency room staff that until she received her Gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. The emergency room physician sent a new prescription for Gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM.

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The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/13/24
- The MAR for 9:00 AM indicated Nurse # 15 documented a "9" and the corresponding administration record note at 10:05 AM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.
- The MAR for 12:00 PM indicated Nurse # 15 documented a "9" and the corresponding administration record note at 1:41 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.
- The MAR for 5:00 PM indicated Nurse # 15 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse # 11 documented a "9" and the corresponding administration record note at 10:52 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy

Pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on the night of 5/13/24.

A 6/7/24 nursing progress note indicated Resident #51 was transferred to the hospital due to a change in condition. Resident #51 remained in the hospital as of 6/19/24 and was unavailable for interview.

An in-person interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 stated there had been delays in receiving refills of gabapentin for the past several months and Resident #51 had gone without medication. Unit Manager #2 was unable to recall

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if Resident #51 reported pain due to not receiving gabapentin but stated gabapentin was ordered for pain so running out of the medication would cause increased pain.

An interview was conducted via phone with Nursing Assistant (NA) #1 on 6/27/24 at 4:17 PM. NA #1 stated she was familiar with Resident #51. NA #1 stated Resident #51 complained of pain at times, but this was not common for her.

An interview was conducted via phone with NA #9 on 6/27/24 at 4:40 PM. NA #9 stated Resident #51 complained of leg pain at times.

A follow up interview was conducted via phone with Nurse #8 on 6/27/24 at 6:15 PM. Nurse #8 stated she was aware of the potential for withdrawal and adverse effects that Resident #51 may sustain because of not receiving the ordered doses of gabapentin. Nurse #8 stated muscle aches and spasms were signs of withdrawal.

An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate). The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe.

An in-person interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for Resident #51 resulting in missed doses of the medication ordered for pain. The DON indicated

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there was confusion regarding the requirements to order and reorder gabapentin and she did not understand the requirements herself. The DON revealed the Consultant Pharmacist had informed her of the problem with gabapentin running out but being new to the DON position, she had not investigated the problem. The DON stated a system was required in the facility to track medication refills, especially medications for pain.

An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected pain medication to be administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identified a medication was not available for administration.

An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. The Physician further indicated it was not right to withhold medication from a resident and it had the potential for adverse outcome. The Physician revealed Resident #51 being sent to the hospital for evaluation due to increased pain was the outcome of not receiving the scheduled doses of the medication gabapentin as ordered by the physician. She stated it was the responsibility of the facility to obtain the medications, especially pain medications, so they could be administered

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as ordered.

2. Resident #46 was admitted on 12/6/23 with diagnosis which included diabetes and neuropathy.

Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain.

A physician order dated 1/18/24 indicated Resident #46 had a PRN (as needed) order for hydrocodone acetaminophen 5-325 milligrams (mg) every 6 hours as needed for pain.

Resident #46's quarterly Minimum Data Set (MDS) assessment dated 3/12/24 indicated resident was cognitively intact. Resident #46 received scheduled and as needed pain medication, pain interview should be conducted, and resident reported no pain in the previous 5 days.

A review of the Medication Administration Record (MAR) for 5/1/24 through 5/9/24 revealed Resident #46 was administered the PRN hydrocodone acetaminophen 10 doses with the highest pain level recorded as 8. Gabapentin 800 mg was administered twice per day from 5/1/24 through 5/9/24.

An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she worked through an agency and was assigned to work at the facility on 5/6/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she was assigned to Resident #46. Nurse #3 indicated a card of gabapentin was delivered for Resident #46 on 5/6/24 but the medication did not have a controlled substance

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sign out sheet, so she asked Nurse #2 what to do. Nurse #3 indicated Nurse #2 returned the card of gabapentin for Resident #46 to the pharmacy with the delivery driver. Nurse #3 stated she did not inform the Unit Manager, Director of Nursing (DON), or pharmacy that the medication was returned as she thought Nurse #2 would have done this.

An interview was conducted with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she worked on 5/6/24 from 7:00 PM to 7:00 AM but she was not assigned to Resident # 46. Nurse #2 recalled the gabapentin was delivered from the pharmacy for Resident #46 on 5/6/24 but it did not have a controlled drug sheet attached. Nurse #2 stated she was told by someone, but she could not recall who, to return the medication to the pharmacy with the delivery driver due to no controlled drug sheet. Nurse #2 indicated she did not inform the Unit Manager, DON or pharmacy that the medication was returned as she thought the nurse assigned to Resident #46 would do it.

The May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM. The MAR specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #46's pain medication:

5/10/24
- The MAR for 9:00 PM indicated Nurse # 3 documented a "9" and there was no corresponding nursing note.
- The MAR at 9:51 PM indicated Nurse #3 administered a PRN dose of hydrocodone

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acetaminophen 5-325 mg for pain. Nurse #3 documented the PRN dose was effective.
5/11/24
- The MAR for 9:00 AM indicated Nurse #6 documented as the medication was administered.
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note.
- The MAR indicated at 9:43 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for a pain level of 7. Nurse #3 documented the PRN dose was effective.
5/12/24
- The MAR for 9:00 AM indicated Nurse #6 documented a "9". The corresponding nursing note at 9:09 AM indicated awaiting pharmacy delivery of gabapentin.
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note.
- The MAR indicated at 9:37 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for a pain level of 9. Nurse #3 documented the PRN dose was effective.
5/13/24
- The MAR for 9:00 AM indicated Nurse #6 documented a "9". The corresponding nursing note at 9:44 AM indicated awaiting pharmacy delivery of gabapentin.
- The MAR for 9:00 PM indicated Nurse # 17 documented a "9". A pain level of 8 was recorded at 10:50 PM. The corresponding nursing note at 10:53 PM indicated the medication on order from pharmacy.
- The MAR indicated at 9:50 PM Nurse #17 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for pain. Nurse #17

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documented the PRN dose was effective.
5/14/24
- The MAR for 9:00 AM indicated Nurse # 7 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse # 17 documented a "9" and there was no corresponding nursing note.
- The MAR indicated at 9:25 PM Nurse # 17 administered an as needed dose of 5-325 mg hydrocodone acetaminophen. Nurse #17 documented the PRN dose was effective.
5/15/24
- The MAR for 9:00 AM indicated Nurse #7 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse # 17 documented a "9" and there was no corresponding nursing note.
5/16/24
- The MAR for 9:00 AM indicated Unit Manager #2 documented a "9". The corresponding nursing note at 9:17 AM indicated waiting for delivery of gabapentin from pharmacy.
- The MAR for 9:00 PM indicated Nurse # 11 documented a "9". The corresponding nursing note on 5/17/24 at 12:40 AM indicated awaiting medication delivery from pharmacy.
5/17/24
- The MAR for 9:00 AM indicated Nurse #5 documented a "9". An administration note dated 5/17/24 at 10:09 AM indicated awaiting medication delivery of gabapentin from pharmacy.
- The MAR for 9:00 PM indicated Nurse #2 documented a "9" and there was no corresponding nursing note. A pain level of 7 was recorded at 9:04 PM.

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An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented 9 on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin and indicated the medication was not administered due to it being unavailable. Nurse #3 stated Resident #46 had pain and was unable to sleep when she did not receive the medication gabapentin. Nurse #3 reported she did not relay Resident #46's reports of increased pain to the physician.

An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart. Nurse #6 indicated Resident #46 was upset about not receiving her scheduled gabapentin due to having increased pain. Nurse #6 did not report the resident's concerns about pain and did not have an explanation for why.

An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse # 17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse # 17 stated she looked for the medication on the medication cart and when she did not see it, she documented it 9, not available. Nurse #17 indicated medications were frequently missing and ran out from the medication cart. Nurse #17 revealed

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gabapentin was prescribed for pain and Resident #46 exhibited increased pain, irritability and anxiety from not receiving the medication. Nurse #17 did not report Resident #46's symptoms to the physician or administration and did not have an explanation for why.

An interview was conducted on 6/13/24 at 3:47 PM with Nurse #16. Nurse #16 was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24 from 7:00 PM to 7:00 AM. Nurse #16 stated she worked at the facility through an agency for about 6 weeks. Nurse #16 stated 9 on the electronic MAR indicated the medication was not available. Nurse #16 indicated she documented "9" for unavailable on Resident #46's MAR on 5/13/24, 5/14/24 and 5/15/24 at 9:00 PM for the scheduled doses of gabapentin. Nurse #16 stated gabapentin was prescribed for pain and Resident #46 reported increased pain and inability to sleep from not receiving her scheduled pain medication.

An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 stated she signed for the dose on the electronic MAR on 5/15/24 at 9:00 AM in error. Nurse #7 recalled gabapentin was not available on the medication cart, but she did not attempt to obtain it or notify the physician. Nurse #7 stated Resident #46 was upset and had increased pain when she did not receive the ordered gabapentin. Nurse #7 stated she was aware that gabapentin

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was prescribed for nerve pain and not receiving the medication would cause the resident to have increased pain. Nurse #7 was unable to explain why she did not report Resident #46's increased pain from not receiving the scheduled doses of gabapentin.

An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered, resident reported increased pain. Unit Manager #2 stated she did nothing about Resident #46's medication not being available and did not have an explanation for why.

An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated there was a problem with running out of medications and administration was aware of the problem with medication not coming in from pharmacy. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM and did not call the pharmacy to obtain it. Nurse #5 stated Resident #46 reported increased pain. Nurse #5 stated she the medication was on order, so she did not attempt to obtain it.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the prescribed dose for Resident #46 on 5/17/24 and the resident reported pain. Nurse #2 stated she

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did not call the pharmacy to obtain the prescribed gabapentin for Resident #46. Nurse #2 stated medications were frequently unavailable, and she was informed by other nurses, although she did not recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done.

Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM. Messages were left on 6/11/24 and 6/12/24 with no return call received.

An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated the facility frequently had trouble obtaining medications. Resident #46 stated she had gone without medications for days at a time on several occasions. Resident #46 reported staff would state the medication was coming from the pharmacy and then it didn't come in. Resident indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not receive her gabapentin. Resident #46 stated it was horrible and the staff told her she would just have to wait it out until the medication came in.

An interview was conducted via phone with Nursing Assistant (NA) #1 on 6/27/24 at 4:17 PM. NA #1 stated she was familiar with Resident #46. NA #1 stated Resident #46 complained of pain at times, but this was not common for her.

An interview was conducted via phone with NA #9 on 6/27/24 at 4:40 PM. NA #9 stated Resident #

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46 was pleasant, quiet and did not usually complain of pain. NA #9 stated Resident #46's normal routine was to get up out of bed to the wheelchair and attend activities daily.

An interview was conducted via phone with Nurse #5 on 6/27/24 at 6:44 PM. Nurse #5 stated she was aware that suddenly stopping gabapentin could lead to withdrawal symptoms including insomnia, nausea, tremors and anxiety. Nurse #5 stated the symptoms Resident #46 reported could have been withdrawal symptoms.

Review of a 5/27/24 Medication Record Review by the Consultant Pharmacist indicated a medication error was identified in Resident #46's electronic health record. The note indicated gabapentin was marked out of stock for 13 doses in May 2024. The Pharmacist indicated on the note that she checked the pharmacy records and found the pharmacy sent a 30-day supply of the medication gabapentin on 5/6/24. Communication was sent to the facility on 5/11/24 and 5/16/24 that the medication was filled on 5/6/24 and would be refilled again on 5/30/24. Please review with staff.

An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate). The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe.

A follow up interview with the Director of Nursing (DON) on 6/12/24 at 4:15 PM revealed the nurses

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on the medication cart were expected to reorder medications within 5-7 days of the supply being depleted. The DON stated she was aware Resident #46 did not receive Gabapentin 800 mg twice per day from 5/10/24 through 5/17/24. The DON stated she started at the facility at the end of March and did not recall when she became aware Resident #46 did not receive the ordered gabapentin. The DON stated there had been problems with the fax machines in the facility for a while and that may have contributed to the problem. The DON expected that resident's pain would be monitored and addressed, and the physician would be notified if a prescribed pain medication was unavailable.

An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected that pain medications would be available and administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identified a medication was not available for administration. The Administrator stated there were problems with the fax machines in the facility and that had affected communication between the facility and the pharmacy.

An interview was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg twice per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the risk of withdrawal and increased pain. Withdrawal symptoms can occur within 12 hours and can be severe. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as

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ordered. The Physician further indicated it was not right to withhold medication from a resident and it had the potential for adverse outcome. The Physician revealed Resident # 46 not feeling well, having increased pain being unable to participate in daily activities was a direct result of not receiving the scheduled pain medication gabapentin. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered.

The Administrator was notified of Immediate Jeopardy on 6/13/24 at 2:15 PM.

The facility provided the following Immediate Jeopardy removal plan:

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

The facility failed to effectively manage pain (Resident #51 and Resident #46).

The facility failed to effectively manage pain by not administering a routine order of gabapentin 800 mg 4 times a day between the dates of 05/08/2024 to 05/13/2024 (Resident #51). Resident #51 complained of pain. On 05/09/2024 Resident #51 refused a shower due to too much pain. On 05/10/2024 Resident #51 complained of her legs feeling numb. On 05/12/2024 Resident #51 complained of pain and spasming in which Resident #51 requested to go to the Emergency Room (ER). Resident #51 returned from the ER where the resident was treated for acute pain and received gabapentin at the hospital. In the evening on 05/12/2024 Resident #51 complained of agitation and anxiety due to not receiving

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gabapentin and requested to go to the ER. Resident #51 received gabapentin in the ER. The facility failed to manage Resident #51's pain by not administering a total of 21 doses of gabapentin between 05/08/2024 and 05/13/2024.

The facility further failed to effectively manage pain by not administering a routine order of gabapentin 800 mg 2 times a day between the dates of 05/10/2024 - 05/17/2024 (Resident #46). Resident #46 had a pain level of 8 or 9 constantly during the time the facility failed to manage her pain. Resident #46 complained of not receiving pain medication which caused her more pain and made it hard to sleep. Resident #46 complained of irritability, being anxious, and nausea. Resident #46 had not felt well and had not been able to get out of bed to participate in activities and perform a daily routine due to pain in her legs.

The facility failed to manage Resident #46's pain by not administering a total of 14 doses of gabapentin between 05/10/2024 and 05/17/2024.

On 06/14/2024 the Director of Nursing identified that all residents have the potential to experience adverse and/or serious outcomes as a result of the deficient practice. The Director of Nursing, Minimum Data Set (MDS) Coordinator, and Unit Managers (UMs) will begin completing pain assessments on all residents to identify any unmet pain needs/change in pain. Cognitively intact residents will be interviewed, and cognitively impaired residents will be assessed for signs or symptoms of pain. This will be completed by 06/15/2024. If there are any concerns identified, the concerns will be reported to the physician immediately to ensure the facility is effectively managing pain.

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete:

The Director of Nursing and Unit Managers (UMs) will begin in person education on 06/14/2024 with all nurses and medication aides which will include all full-time, part-time, as needed, and agency staff. This education will be on the importance of providing pain medications per the physician's orders, ensuring appropriate pain management to control the resident's level of pain, if the resident's pain is not controlled the physician must be called for further treatment, and if the medication is not available, they must call the physician to get alternate treatment that is available per physician's orders. No nurses or medication aides will work after 06/14/2024 until they have received the education. The Director of Nursing will be responsible for keeping up with those nurses and medication aides who have and have not been educated. The Director of Nursing is responsible for completing the education or assigning the UM to complete the education for any staff who has not been educated by 06/14/2024. The UMs were notified of their responsibility on 06/14/2024 by the Director of Nursing.

On 06/14/2024 education begin for all nurse aides which will include all full-time, part-time, as needed, and agency staff on reporting signs and symptoms of pain to nurses and/or medication aides beginning immediately on 06/14/2024. No nurse aide will work at the facility until education has been received. The Director of Nursing will be responsible for keeping up with those nurse

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aides who have and have not been educated. The Director of Nursing is responsible for completing the education or assigning the UM to complete the education for any staff who has not been educated by 06/14/2024. The UMs were notified of their responsibility on 06/14/2024 by the Director of Nursing.

All newly hired nurses, medication aides, and nurse aides (full-time, part-time, as needed, and agency) will be educated as noted above. This will be completed by the Director of Nursing. The Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Director of Nursing is responsible for completing the education with new hires. The Director of Nursing was notified of this responsibility on 06/14/2024 by the Administrator.

Alleged immediate jeopardy removal date: 06/16/2024

The removal plan of the Immediate Jeopardy was validated on 06/19/24. A sample of staff including the Administrator, Unit Manager, Nurses, Medication Aides and Nursing Assistants were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they had been in- serviced regarding providing pain medications according to the physician order, ensuring pain management to control the resident's level of pain, and identifying when a resident was having pain. The facility staff to include the Director of Nursing, MDS Coordinator and Unit managers, completed pain assessment audits on all residents to identify any unmet pain or change in pain. All cognitively impaired residents were assessed for signs or symptoms of pain. Pain assessment audits were

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F 697	Continued From page 150 reviewed. Nursing staff stated if a resident complained of new pain or was showing signs and/or symptoms of new pain, a pain assessment should be completed, and the physician should be notified for any new interventions. Nursing staff stated if there were no ordered pain medications available, they would need to check the emergency medication system to see if the medication was available and if not available, they were to notify the provider. The removal date of 6/16/24 was validated.	F 697		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a physician visit occurred	F 712	The facility failed to ensure a physician visit occurred for a resident within 30 days	7/27/24

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F 712	Continued From page 151 for a resident within 30 days from admission for 1 of 8 sampled residents reviewed for physician visits (Residents #48). Findings included: Resident #48 was admitted to the facility on 05/03/24. Her diagnoses included congestive heart failure, dementia, depression, anxiety, pain, seizures, hallucinations, and edema. The quarterly Minimum Data Set (MDS) dated 05/29/24 indicated Resident #48 had moderate cognitive impairment. Review of Resident #48's Electronic Medical Record (EMR) revealed she was not seen by the attending physician. Review of Resident #48's EMR revealed she was seen by Nurse Practitioner (NP) on 05/14/24. An interview was conducted on 06/14/24 at 11:15 AM with the Administrator. She stated their past Medical Director (MD) was not personally visiting their facility as often as he should have. The Administrator the stated reason for switching MD companies, was for that reason, MD was not visiting on site as often as needed. An interview was conducted on 06/14/24 at 3:45 PM with the Director of Nursing (DON). She stated the previous Medical Director (MD) was not visiting their facility as often as he should have. The DON revealed Resident #48 was admitted on 05/03/24 and had only been seen by a NP on 05/14/24, but never personally by her attending physician.	F 712	from admission for 1 of 8 sampled residents reviewed for physician visits (Residents #48). Resident #48 received a medication regimen review by the Primary Care Provider who was the facility's Medical Director on 5/7/2024. Resident #48 was seen on 5/14/2024 by the facility Nurse Practitioner (NP). Resident #48 is on hospice services and received a hospice comprehensive assessment on 6/20/2024. Resident #48 was seen on 6/21/2024 by the current facility Nurse Practitioner (NP). Resident will be seen by the current Primary Care Provider who is the facility's Medical Director on 8/6/2024. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA) who became the LNHA at the facility in February 2024, recognized that the physician who was appointed as the active Medical Director for the facility in November 2023 was the active primary care physician (PCP) for the facility. The LNHA identified that the active Medical Director who was also the PCP was not visiting residents as expected per the regulations and the expectation of quality of care was not being met. The LNHA recognized that the PCP was not communicating with the Director of	

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F 712	Continued From page 152	F 712		

Nursing (DON) or other contractual providers who provide medical services to the facility such as the mental health providers and consultant pharmacist when necessary.

The LNHA recognized the need for continuous effective and efficient quality of care for all residents. The LNHA submitted a 30-day written termination notice on May 7th, 2024, to the medical group that the active Medical Director who was also the PCP was contracted with. The active Medical Director who was also the PCP and all other medical providers and medical services obtained from the medical group were terminated from the facility as of June 7th, 2024, with adherence to the 30-day written termination notice that the LNHA initiated per the agreed contract that was signed prior to the LNHA taking over the LNHA position at the facility in February 2024.

The LNHA initiated contact with a different medical group and pursued a contract with this group for a Medical Director who would also serve as the PCP. The contract also included services from other medical providers such as a Nurse Practitioner to visit the facility and medical services to be utilized in the facility. The services offered under the contract consist of but are not limited to telemedicine sessions, visits to the facility at minimum of three times a week one of which includes a visit the PCP who is also under active Medical Directorship, and 24 hours/7 days a week/365 days a year to

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F 712	Continued From page 153	F 712	an on-call provider. This contract began on June 7th, 2024. The LNHA or Designee will educate the newly contracted PCP who is also under active Medical Directorship for the facility and the assigned facility Nurse Practitioner by 8/5/2024 on the regulation regarding timely resident visits upon admission. After 8/5/2024 if there are any newly hired Medical Directors, PCPs, or Nurse Practitioners they will be educated by the LNHA or Designee upon their hire. Beginning 7/27/2024, the LNHA, DON, or Designee will audit all new admissions for 12 months to verify that the PCP has visited each new resident in a timely manner. Any new admission identified as not being seen by the PCP within the required timeframe will be communicated to the PCP. The expectation is that the PCP visits the resident within 24 hours of being notified to correct the action and ensure compliance. If the PCP does not see a new admission within the required timeframe it will result in re-education with the appropriate medical provider and will be communicated to the medical group that the PCP is contracted under, and disciplinary action will be taken if necessary. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI)	

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F 712	Continued From page 154	F 712	Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726		7/27/24

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F 726	Continued From page 155 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure staff were trained and competent in the process to obtain medications from the pharmacy for 10 of 10 staff (Nurse #8, Nurse #9, Nurse #3, Nurse #6, Nurse #17, Nurse #16, Nurse #7, Unit Manager #1, Unit Manager #2, and the Director of Nursing) reviewed for pharmacy procedures for obtaining medications. Findings included: 1a. Resident #51 was admitted on 10/19/23. Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. The May 2024 MAR indicated Resident #51's gabapentin was not administered as ordered from 5/8/24 through 5/13/24 due to the medication not being obtained from the pharmacy. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 indicated she did not know the process for obtaining medications from the pharmacy and had been informed by other nurses, although she did not recall which nurses, that if a medication was not available, they just had to wait for it to come in.	F 726	The facility failed to ensure staff were trained and competent in the process to obtain medications from the pharmacy for 10 of 10 staff (Nurse #8, Nurse #9, Nurse #3, Nurse #6, Nurse #17, Nurse #16, Nurse #7, Unit Manager #1, Unit Manager #2, and the Director of Nursing) reviewed for pharmacy procedures for obtaining medications). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will review all nurse competencies to ensure they are up to date by 8/5/2024. The DON or Designee will educate all nursing staff by 8/5/2024 on the policy/procedure for obtaining medications from the pharmacy. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit nurse competencies to ensure all education is given annually. Any missing competencies will result in	

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F 726	Continued From page 156 An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse #9 was assigned to Resident #51 on 5/9/24 and 5/10/24. Nurse #9 stated she did not attempt to obtain medication for Resident #51 and did not know the process for obtaining gabapentin. An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24. Unit Manager #1stated she was unclear about the requirements for reordering gabapentin. An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 stated she had been told by other nurses, although she was not able to recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done about the medications not being available. Nurse #2 indicated she was not familiar with the process at the facility for ordering and reordering medications. 1b. Resident #46 was admitted on 12/6/23. Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain. Resident #46's May 2024 Medication Administration Record (MAR) indicated gabapentin was not administered as ordered from 5/10/24 through 5/17/24 due to the medication not being obtained from the pharmacy.	F 726	re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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An interview was conducted via phone with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24. Nurse #3 stated she was unaware of the process to obtain the medication and she did not inquire about how to obtain it.

An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. She worked with Resident #46 on 5/11/24, 5/12/24, and 5/13/24. Nurse #6 stated she was not aware of the process for obtaining a medication that was not available.

An interview was conducted via phone on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse # 17 stated she was assigned to Resident #46 on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated was not aware of the process for obtaining medications for residents.

An interview was conducted via phone on 6/13/24 at 3:47 PM with Nurse #16. Nurse #16 was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24. Nurse #16 stated she worked at the facility through an agency for about 6 weeks. Nurse #16 stated she was not aware of the process to obtain medications.

An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24. Nurse #7 stated she was unaware of the process for obtaining a medication that was not available.

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An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she did not know the process for obtaining gabapentin and did not know if a written or electric prescription was needed to reorder gabapentin. Nurse #5 stated she was assigned to Resident #46 on 5/17/24.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24. She indicated she did not know the process for ordering and reordering medications.

An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks. Unit Manager #1 stated she thought gabapentin required a written or electronic prescription to be refilled but it had been a while since she ordered it, so she was not sure.

An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 stated she thought a written or electronic prescription was required to obtain a refill of gabapentin, but she was not sure.

An interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON indicated there was confusion regarding the requirements to order and reorder gabapentin and she did not understand the requirements herself.

An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. She stated nursing staff did not have a comprehensive

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F 726	Continued From page 159 understanding of what to do when they identified a medication was not available for administration.	F 726		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 17 of 130 days reviewed for sufficient staffing (2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024). Finding included: The Payroll Based Journal (PBJ) report for the first quarter of 2024 (January, February, March) reported the facility without RN coverage for eight consecutive hours per day.	F 727	The facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 17 of 130 days reviewed for sufficient staffing (2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home	7/27/24

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F 727	Continued From page 160 A review of the daily census posting sheets for the months of February 2024 to June 9, 2024, reported a constant census greater than 60 residents in the facility and no RN coverage for eight consecutive hours for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024. A review of the daily nursing staffing sheets for the months of February 2024 to June 9, 2024, indicated there was no RN scheduled for at least eight consecutive hours for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024. There was no RN recorded as working eight consecutive hours on the timecard records reviewed for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024. In a phone interview with Unit Manager #2 on 6/19/2024 at 11:57 am, she explained she had been responsible for the schedule since April 30, 2024 and knew there was to be a RN scheduled daily for eight consecutive hours. She explained she tried to ensure a RN was scheduled for at least eight hours a day and would call staff to attempt to cover the days when a RN was not scheduled. She stated when she was unable to schedule an RN for eight consecutive hours for a	F 727	Administrator (LNHA) and Director of Nursing (DON) had already determined prior to the cited deficiency being given that there has been a trending pattern of failure for the facility not having a Registered Nurse (RN) scheduled for at least eight consecutive hours per day seven days a week; specifically trending on weekends for a minimum of two years when investigating this identified issue. The LNHA and DON also identified prior to the cited deficiency being given that there has been a trending pattern of failure for current and previous hired RNs not staying clocked into the work system for at least eight consecutive hours when working as the dedicated RN coverage. For example, 7.62 continuous hours worked, or 7.98 continuous hours worked. The LNHA and DON are continuing to actively search for RNs to work at the facility and are proceeding with hiring RNs for the facility to ensure compliance. Since the survey, 2 RNs have been hired. The facility is attempting to continue the ongoing seeking of RNs to hire additional staff to ensure compliance with the staffing regulation. The LNHA and DON have hired a Minimum Data Set (MDS) RN, Staff Development Coordinator (RN), and agency RNs to assist in ensuring compliance. The LNHA, DON, Staff Development Coordinator (RN), and Human Resources Coordinator continue to utilize newspaper ads, fliers, job fairs, local community college nursing program engagement, and local community	

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F 727	Continued From page 161 day, the Director of Nursing (DON) and Administrator were informed, and the unit managers (who were not RNs) covered shifts if needed. In a phone interview with the DON on 6/19/2024 at 10:22 am, she stated when she started at the facility in March 2024 there was not a sufficient number of registered nurses on the schedule to cover the required eight consecutive hours per day of RN coverage. She said due to the census greater than 60 residents consistently, she was not able to serve as the RN coverage and there was an RN on-call daily when not in the facility. She stated the administrative team was aware of not having RN coverage for the eight consecutive hours daily at times due to not having a Minimum Data Set (MDS) Nurse in the facility and RN not scheduled on the weekends. She explained the facility recognized the problem and had worked on hiring registered nurses and had been using agency RN staff. In a phone interview with the Administrator on 6/19/2024 at 12:25 pm, she explained the daily nursing schedule was ultimately the DON responsibility to ensure there was a RN that worked eight consecutive hours daily in the facility and stated since February when she started at the facility, she was aware there was an issue with providing a RN eight consecutive hours daily in the facility. She further explained the resignation of MDS Nurses and the DON's inability to serve as the RN coverage due to a constant daily census greater than 60 residents impacted the facility's inability to provide RN coverage for eight consecutive hours daily. The Administrator stated she hired a MDS Nurse, registered nurses and agency registered nurses	F 727	engagement to recruit RN staff to ensure compliance is achieved. The DON, RN Nursing Supervisor, and Unit Manager who assist with nursing scheduling are aware of the requirement for RN coverage at least eight consecutive hours per day seven days a week. The facility will attempt to schedule RN staff accordingly to ensure the deficient practice does not recur. The LNHA or Designee will educate the DON, RN Nursing Supervisor, and Unit Manager by 8/5/2024 on the regulation related to the requirement for RN coverage at least eight consecutive hours per day seven days a week. The DON or Designee will educate all RNs that work at the facility by 8/5/2024 on the regulation related to the requirement for RN coverage at least eight consecutive hours per day seven days a week to ensure the RNs are staying clocked in for the eight consecutive hours during their shifts. After 8/5/2024 newly hired RNs will be educated by the DON or Designee during their new hire employee orientation. The LNHA or Designee will educate the DON, RN Nursing Supervisor, and Unit Manager by 8/5/2024 on the communication of all RN staffing needs/challenges, RN vacant positions, or additional coverage needs being communicated to the LNHA as necessary. After 8/5/2024 newly hired staff will be	

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F 727	Continued From page 162 to help cover the RN for eight consecutive hours issue and continued to use newspaper ads, fliers and job fairs to recruit RN staff due to resignations of RN staff.	F 727	educated by the LNHA, DON or Designee during their new hire employee orientation. The LNHA or Designee will educate the Human Resources Coordinator by 8/5/024 on the need to review current RN applications and advertising for the open RN positions through recruiters, agencies, and media platforms as necessary. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning on 7/27/2024 the LNHA, DON, or Designee will audit PBJ Reports and nursing RN schedules monthly for 6 months and as further necessary to ensure RN coverage at least eight consecutive hours per day seven days a week is scheduled daily to meet the current regulatory requirements. Beginning on 7/27/2024 the LNHA, DON, or Designee will audit how many RNs apply for a RN job at the facility and how many RNs are hired at the facility monthly for 6 months. Beginning 7/27/2024 the LNHA, DON, or Designee will audit currently hired RNs time on a daily basis to ensure they are clocked in when working for at least eight consecutive hours for six months and as further necessary. If there are any newly hired RNs to begin working at the facility they will also be audited. If it is identified that an RN was the dedicated RN coverage for at least eight consecutive	

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F 727	Continued From page 163	F 727	hours and did not fulfill this requirement it will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a performance review every 12 months for 1 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (Medication Aide #5).	F 730	The facility failed to complete a performance review every 12 months for 1 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (Medication Aide	7/27/24

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F 730	Continued From page 164 Findings included: Medication Aide #5's personnel file was reviewed and revealed a date of hire of 11/8/2019. The personnel file for Medication Aide #5 did not include evidence a performance review had been completed since the Medication Aide #5's date of hire. A phone interview was conducted on 7/1/2024 at 1:23 pm with Medication Aide #5. During the interview, Medication Aide #5 stated her annual performance evaluation was due in November 2023 and had not received a performance evaluation in the last year. A phone interview was conducted on 6/19/24 at 10:22 am with the Director of Nursing (DON). During the interview, the DON stated since starting at the facility in March 2024, she had not conducted a performance review for Medication Aide #5. The DON did not provide a reason as to why she had not conducted an annual performance review for Medication Aide #5. A phone interview was conducted on 6/19/24 at 12:25 pm with the Administrator who stated the DON was responsible for conducting the annual performance review for Medication Aide #5 and did not know the DON had not conducted the annual performance review.	F 730	#5). The Director of Nursing (DON), Staff Development Coordinator Registered Nurse (RN), or Designee will review the education that has been provided to the nurse aides from, January 2024, until current by 8/5/2024 to ensure ongoing education is being provided. The Licensed Nursing Home Administrator (LNHA) and DON have determined that there has been a trending pattern of failure for the facility not having a full-time Staff Development Coordinator Registered Nurse (RN) for at minimum of one year when investigating this identified issue. However, the LNHA has hired a full-time Staff Development Coordinator RN. The LNHA, DON, or Designee will educate the Staff Development Coordinator RN by 8/5/2024 on the importance of ongoing education for all nursing staff employed at the facility and will educate on assisting in the formation and completion of an annual educational calendar that will be available for all staff as of 8/5/2024. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the LNHA, DON, or Designee will audit employee education records monthly for 12 months to ensure ongoing education is being completed for all nursing staff. Any month identified that education was not completed will result in re-education and additional training for the	

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F 730	Continued From page 165	F 730	appropriate staff member. If there are any newly hired nursing staff to begin working at the facility they will also be audited. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	
F 755 SS=K	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed 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.	F 755		7/27/24

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F 755	Continued From page 166 §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, resident, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, and Physician interview, the facility failed to ensure scheduled medication was obtained and available for administration for 3 of 10 residents (Resident #51, Resident #46, and Resident #8) reviewed for medications. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) on 5/12/24 in the middle of the night after missing 14 doses of the medication. She was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3	F 755	The facility failed to ensure scheduled medication was obtained and available for administration for 3 of 10 residents (Resident #51, Resident #46, and Resident #8) reviewed for medications. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #51 missed a total of 21 doses of the medication from 5/8/2024 through 5/13/2024. Resident #51 had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and	

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F 755	Continued From page 167 more doses of gabapentin on 5/12/24 and returned to the ED that evening for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, Resident #8 was prescribed Oxycodone/Acetaminophen (opioid medication) 10/325 mg and this medication was not obtained from the pharmacy resulting in multiple missed doses of the medication. Immediate Jeopardy began on 5/9/24 for Resident #51 when the facility failed to obtain the ordered medication gabapentin from the pharmacy resulting in a reported pain scale of 10 out of 10. Immediate Jeopardy began on 5/12/24 for Resident #46 when the facility failed to obtain the ordered medication gabapentin from the pharmacy resulting in increased pain and difficulty sleeping. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Example #3 was cited at scope and severity "E".	F 755	spasms. She was transferred to the Emergency Department (ED) on 5/12/2024 in the middle of the night after missing 14 doses of the medication. She was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/2024 and returned to the ED that evening for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Her medication required a prescription to be faxed to the pharmacy. A note was left for the provider on 5/11 requesting a prescription to be signed. Resident #51 requested this medication and was told by he nurse that they were waiting for the prescription to be signed by the provider, and she verbalized understanding of this process. Resident #51 requested to be sent back out to the ED on 5/12 and returned to the facility approximately 4 hours later. She was told the prescription would be signed on Monday (5/13) and would be faxed to the pharmacy to be filled. On 5/13, resident #51 requested to be sent back to the ED and stated she would keep requesting to go out to the ED until her prescription was filled. She returned to the facility that day with a prescription sent to the pharmacy from the ED doctor. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not obtained from the	

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F 755	Continued From page 168 Findings included: 1. Resident #51 was admitted on 10/19/23 with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities). Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. Review of Resident #51's quarterly Minimum Data Set (MDS) dated 4/4/24 indicated resident was cognitively intact and exhibited no behaviors. The MDS assessment was coded as received scheduled and as needed pain medication. The pain interview was not assessed. The pharmacy records indicated a supply of 120 gabapentin 800 mg pills was sent to the facility for Resident #51 on 4/25/24. The pharmacy record indicated 92 gabapentin pills from the 4/25/24 supply for Resident #51 were returned to the pharmacy while Resident #51 was in the hospital from 5/5/24 through 5/8/24. The hospital discharge summary dated 5/8/24 indicated Resident #51 was hospitalized from 5/5/24 through the morning of 5/8/24. The hospital indicated the order for gabapentin for Resident #51 was unchanged when she was discharged on 5/8/24. A nursing progress note written by Nurse #8 on 5/8/24 at 4:22 PM revealed Resident #51 returned to the facility from the hospital on 5/8/24	F 755	pharmacy and Resident #46 missed 14 doses of the medication from 5/10/2024 through 5/17/2024 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. The DON has scheduled pain assessments to be completed by the nurses to ensure her pain is now being managed effectively. Additionally, Resident #8 was prescribed Oxycodone/Acetaminophen (opioid medication) 10/325 mg, and this medication was not obtained from the pharmacy resulting in multiple missed doses of the medication. On 2/14 and 3/27, the NP notes indicated that the resident had no complaints of pain. The DON has scheduled pain assessments to be completed by the nurses to ensure her pain is being managed effectively. Immediate Jeopardy began on 5/9/2024 for Resident #51 when the facility failed to obtain the ordered medication gabapentin from the pharmacy resulting in a reported pain scale of 10 out of 10. Immediate Jeopardy began on 5/12/2024 for Resident #46 when the facility failed to obtain the ordered medication gabapentin from the pharmacy resulting in increased pain and difficulty sleeping. Upon identification of the severity of the alleged deficient practices, the Licensed Nursing Home Administrator (LNHA) wrote the Immediate Jeopardy Removal Plan and submitted the Removal Plan for approval. The Immediate Jeopardy was	

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F 755	Continued From page 169 at 2:40 PM. Resident #51's May 2024 Medication Administration Record (MAR) indicated there was no routine pain monitoring. The May 2024 MAR indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/8/24 - The MAR for 5:00 PM indicated Nurse #8 documented a "9" and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy. - The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note. 5/9/24 - The MAR for 9:00 AM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note. Following readmission to the facility on 5/8/24, a pain assessment dated 5/9/24 was completed by Nurse #9. The pain assessment indicated	F 755	removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The LNHA terminated the agency Director of Nursing (DON) during extended survey on 6/19/2024. The LNHA hired an experienced non-contractual DON on 6/19/2024 to ensure future compliance. The facility has also hired nursing staff including RNs and LPNs to ensure future compliance. The DON or Designee will review all Medication Administration Records (MARs) for residents receiving medications by 8/5/2024 to ensure there are no missing doses. All missing doses will be reported to the provider and documentation will follow to ensure compliance by 8/5/2024. The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the steps to follow when a medication is not in stock, as well as proper documentation that describes all the steps that were taken to ensure the resident receives their medications as ordered to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will educate all nurses by 8/5/2024 on the importance of completing pain assessments daily for all residents that are receiving medications to ensure compliance. After 8/5/2024 newly hired nursing staff will be educated by the	

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F 755	Continued From page 170 Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 stated "9" documented on the MAR indicated the medication was not available. If a medication was not available, she stated she would wait a few days and then notify Unit Manager #1. Nurse #8 indicated she did not know the process for obtaining medications from the pharmacy and had been informed by other nurses, although she did not recall which nurses, that if a medication was not available, they just had to wait for it to come in. Nurse #8 stated she did not recall when, but she knew she notified Unit Manager #1 that Resident #51's gabapentin was not available. Nurse # 8 stated frequently medications were not available. Nurse #8 stated a written or electronic prescription was not required to reorder gabapentin. Nurse # 8 stated Resident #51 was frustrated about not receiving the medication gabapentin as order. A nursing progress note by Nurse #13 on 5/10/24 at 3:24 AM indicated Resident #51 reported her legs were numb. The note indicated the nurse informed Resident #51 there were no interventions for this and offered emergency	F 755	DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit medication administrations 5 times per week for 12 weeks to ensure all medications are given as ordered. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the DON or Designee will interview 3 residents per week x 12 weeks to ensure his/her pain is being managed effectively. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Any pain that a resident expresses that is not being managed effectively will be reported to the provider. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective	

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F 755	Continued From page 171 room evaluation. Resident #51 declined to be sent to the emergency room. The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/10/24 - The MAR for 9:00 AM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #13 documented a "9" and the corresponding administration record note at 10:12 PM indicated the facility was awaiting delivery of gabapentin 800 mg from pharmacy. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse #9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse #9 stated Resident #51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse #9 revealed she documented "9" which indicated the medication was not available for the doses. Nurse #9 indicated Resident #51 refused her shower on 5/9/24 which was not normal for her, reporting she was in too much pain. Nurse #9 stated the facility frequently ran out of medications and did not receive medications on time. Nurse #9 stated she did not attempt to obtain medication for Resident #51 and did not know the process for obtaining gabapentin.	F 755	action.	

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Attempts were made to interview Nurse #13 via phone with messages left on 6/13/24 and 6/14/24 with no return call received.

The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/11/24
- The MAR for 9:00 AM indicated Unit Manager #1 documented a "9" and there was no corresponding nursing note.
- The MAR for 12:00 PM indicated Unit Manager #1 documented a "9" and there was no corresponding nursing note.
- The MAR for 5:00 PM indicated Nurse #14 documented a "9" and the corresponding progress note on 5/11/24 at 4:15 PM indicated gabapentin 800 mg was pending from the pharmacy and the nurse pass on information to next shift to follow up.
- The MAR for 9:00 PM indicated Nurse #2 documented a "9" and there was no corresponding nursing note.

An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not recall if she made any attempt to obtain the medication for Resident #51. She stated she was unclear the requirements for reordering gabapentin and did not assess Resident #51 for pain.

Attempts were made to interview Nurse #14 via

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phone with messages left on 6/13/24 and 6/14/24 with no return call received.

A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to emergency room. Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal.

An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated for a chief complaint that the facility had been out of her gabapentin for a couple of days and now she was experiencing full body cramps. The ED Summary stated Resident #51 presented to the ED on 5/12/24 at 4:22 AM and reported she had not had her gabapentin and thought she was in gabapentin withdrawal. While in the ED, at 4:43 AM on 5/12/24 Resident #51 was administered gabapentin 800 mg. The discharge instructions were to restart gabapentin 800 mg 4 times per day, to follow up with her primary care physician and to not stop taking prescription medication for pain suddenly. Resident #51 was discharged back to the facility on 5/12/24 at 6:11 AM.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM and was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Resident #51 requested to be sent to the

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hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider and sent Resident #51 to the hospital. Nurse #2 stated medications were frequently not available in the facility. Nurse #2 stated she had been told by other nurses, although she was not able to recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done about the medications not being available.

A progress note written by Agency Nurse #14 on 5/12/24 at 10:09 AM indicated Resident #51 returned from the hospital at approximately 8:00 AM. Unit Manager #1 was made aware on 5/11/24 that Resident #51 had not received her medications from the pharmacy. Unit Manager #1 wrote down the medication that was needed from the pharmacy. The resident was sent to the emergency room last night to obtain gabapentin.

The MAR for 5/12/24 revealed Nurse #14 inaccurately documented a "6" for the 9:00 AM, 12:00 PM, and 5:00 PM doses of Resident #51's gabapentin which indicated the resident was in the hospital. (Resident #51 returned from the ED on 5/12/24 at approximately 8:00 AM [per Nurse #14's progress note] and the next scheduled dose of gabapentin was due at 9:00 AM).

Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. Nurse #14 worked at the facility through an agency.

A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident

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#51 complained of worsening "muscle spasms all over" and requested to go to the emergency department. 911 was called for transfer to the emergency room. Resident #51 returned to the facility having received Gabapentin at the emergency room. Resident #51 told the emergency room staff that until she received her Gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. Emergency room physician sent a new prescription for Gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM.

An ED Summary dated 5/12/24 at 8:50 PM indicated Resident #51 presented with muscle spasms and reported she was unable to get her gabapentin prescription refilled at the nursing facility and was having breakthrough pain. The Medication Administration Record for the ED indicated Resident #51 was administered gabapentin 800 mg on 5/12/24 at 9:12 PM. Resident #51 was discharged back to the facility on 5/12/24 at 9:41 PM with instructions to continue with gabapentin 800 mg 4 times per day.

The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/13/24
- The MAR for 9:00 AM indicated Nurse #15 documented a "9" and the corresponding administration record note at 10:05 AM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.
- The MAR for 12:00 PM indicated Nurse #15 documented a "9" and the corresponding administration record note at 1:41 PM indicated

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the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.
- The MAR for 5:00 PM indicated Nurse #15 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse #11 documented a "9" and the corresponding administration record note at 10:52 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy

Pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on the night of 5/13/24.

A 6/7/24 nursing progress note indicated Resident #51 was transferred to the hospital due to a change in condition. Resident #51 remained in the hospital as of 6/19/24 and was unavailable for interview.

An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks. Unit Manager #1 stated she thought gabapentin required a written or electronic prescription to be refilled but it had been a while since she ordered it so she was not sure. Unit Manager #1 stated she knew gabapentin had to be kept in the narcotic locked box and signed for. Unit Manager #1 stated she was aware that Resident #51 ran out of gabapentin and required emergency room evaluation due to increased pain but did not recall when or how she became aware. Unit Manager #1 indicated she did not recall if she had been involved in obtaining the medication gabapentin for Resident #51.

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An in-person interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 stated she thought a written or electronic prescription was required to obtain a refill of gabapentin, but she was not sure. Unit Manager #2 stated there had been delays in receiving refills of gabapentin for the past several months and Resident #51 had gone without medication. Unit Manager #2 was unable to recall if Resident #51 had pain due to not receiving gabapentin. Unit Manager #2 stated she had not contacted the pharmacy to obtain the ordered medication gabapentin for Resident #51.

An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist indicated there was a system process problem with the facility and the ordering and reordering of medications, including gabapentin. The Consultant Pharmacist stated there was confusion in the facility regarding the requirements for ordering and reordering gabapentin and this placed the residents at risk of adverse effects. The Consultant Pharmacist stated she discussed the problems with obtaining medications for administration when the current Director of Nursing (DON) came into the position at the facility (DON started position in the end of March) and made her aware of the concerns. Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate). The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe. The Consultant Pharmacist indicated the pharmacy considered gabapentin a controlled medication for storage and accounting purposes but did not require a written or

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electronic prescription for refills.

An interview was conducted by phone with the Pharmacy Quality Assurance Specialist on 6/12/24 at 11:50 AM. The Pharmacy Quality Assurance Specialist indicated the pharmacy treated gabapentin as a controlled medication in terms in the storage and accounting for it. She stated a written or electronic prescription was not required to obtain the medication from the pharmacy. The Pharmacy Assurance Specialist stated the process for obtaining a refill of the medication gabapentin was the facility sent the refill sticker via fax or completed a refill request in the computer.

An in-person interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for Resident #51. The DON indicated there was confusion regarding the requirements to order and reorder gabapentin and she did not understand the requirements herself. The DON revealed the Consultant Pharmacist had informed her when she started at the facility at the end of March of the problem with gabapentin not being available. Being new to the DON position, she had not investigated the problem. The DON stated a system was required in the facility to track medication refills.

An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications would be available and administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identify

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that a medication was not available for administration.

An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. The Physician further indicated it was not right to withhold medication from a resident and it had the potential for adverse outcome. The Physician revealed Resident #51 being sent to the hospital for evaluation due to increased pain was the outcome of not receiving the scheduled doses of the medication gabapentin as ordered by the physician. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered.

2. Resident #46 was admitted on 12/6/23 with diagnosis which included diabetes and neuropathy.

Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain.

Resident #46's quarterly Minimum Data Set (MDS) assessment dated 3/12/24 indicated resident was cognitively intact with no behaviors. Resident #46 received scheduled and as needed pain medication, pain interview should be conducted, and resident had no pain in the previous 5 days.

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A physician order dated 1/18/24 indicated Resident #46 had a PRN (as needed) order for hydrocodone acetaminophen 5-325 milligrams (mg) every 6 hours as needed for pain.

A review of the Medication Administration Record (MAR) for 5/1/24 through 5/9/24 revealed Resident #46 was administered the PRN hydrocodone acetaminophen 10 doses with the highest pain level recorded as 8.

An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she worked on 5/6/24 from 7:00 PM to 7:00 AM and was assigned to Resident #46. Nurse #3 indicated a card of gabapentin was delivered for Resident #46 on 5/6/24 but the medication did not have a controlled substance sign out sheet, so she asked Nurse #2 what to do. Nurse #3 indicated Nurse #2 returned the card of gabapentin for Resident #46 to the pharmacy with the delivery driver. Nurse #3 stated she did not inform the Unit Manager, Director of Nursing (DON), or pharmacy that the medication was returned as she thought Nurse #2 would have done this.

An interview was conducted with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she worked on 5/6/24 from 7:00 PM to 7:00 AM but she was not assigned to Resident #46. Nurse #2 recalled the gabapentin was delivered from the pharmacy for Resident #46 on 5/6/24 but it did not have a controlled drug sheet attached. Nurse #2 stated she was told by someone, but she could not recall who, to return the medication to the pharmacy with the delivery driver due to no controlled drug sheet. Nurse #2 indicated she did not inform the Unit Manager, DON or pharmacy

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that the medication was returned as she thought the nurse assigned to Resident #46 would do it.

Review of a Controlled Drug Record for Resident #46 revealed the last dose from the supply of gabapentin delivered on 4/8/24 was signed out by Nurse #7 on 5/10/24 at 8:00 AM bringing the count to 0 pills remaining.

Resident #46's May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM. The MAR further indicated there was no routine monitoring of Resident #46's pain level.

The May 2024 MAR specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #46's pain medication:

5/10/24
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note.
- The MAR at 9:51 PM indicated Nurse #3 administered a PRN dose of hydrocodone acetaminophen 5-325 mg for pain.

5/11/24
- The MAR for 9:00 AM indicated Nurse #6 documented as the medication was administered.
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note. A pain level of 7 was recorded at 9:43 PM.
- The MAR indicated at 9:43 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen.

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5/12/24
- The MAR for 9:00 AM indicated Nurse #6 documented a "9". The corresponding nursing note at 9:09 AM indicated awaiting pharmacy delivery of gabapentin.
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note. A pain level of 9 was recorded at 9:37 PM.
- The MAR indicated at 9:37 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen.

5/13/24
- The MAR for 9:00 AM indicated Nurse #6 documented a "9". The corresponding nursing note at 9:44 AM indicated awaiting pharmacy delivery of gabapentin.
- The MAR for 9:00 PM indicated Nurse #17 documented a "9". A pain level of 8 was recorded at 10:50 PM. The corresponding nursing note at 10:53 PM indicated the medication on order from pharmacy.
- The MAR indicated at 9:50 PM Nurse #17 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for pain.

5/14/24
- The MAR for 9:00 AM indicated Nurse #7 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse # 17 documented a "9" and there was no corresponding nursing note.
- The MAR indicated at 9:25 PM Nurse #17 administered an as needed dose of 5-325 mg hydrocodone acetaminophen.

5/15/24
- The MAR for 9:00 AM indicated Nurse #7 documented a "9" and there was no corresponding nursing note.

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- The MAR for 9:00 PM indicated Nurse #17 documented a "9" and there was no corresponding nursing note.
5/16/24
- The MAR for 9:00 AM indicated Unit Manager #2 documented a "9". The corresponding nursing note at 9:17 AM indicated waiting for delivery of gabapentin from pharmacy.
- The MAR for 9:00 PM indicated Nurse #11 documented a "9". The corresponding nursing note on 5/17/24 at 12:40 AM indicated awaiting medication delivery from pharmacy.
5/17/24
- The MAR for 9:00 AM indicated Nurse #5 documented a "9". An administration note dated 5/17/24 at 10:09 AM indicated awaiting medication delivery of gabapentin from pharmacy.
- The MAR for 9:00 PM indicated Nurse #2 documented a "9" and there was no corresponding nursing note. A pain level of 7 was recorded at 9:04 PM.

An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented 9 on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin and indicated the medication was not administered due to it was unavailable. Nurse #3 stated she was unaware of the process to obtain the medication and she did not follow up to obtain the medication. Nurse #3 stated Resident #46 had pain and was unable to sleep which was a change from the norm when she did not receive the medication gabapentin.

An interview was conducted with Nurse #6 on

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6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she administered the prescribed dose of gabapentin on 5/11/24 at 9:00 AM from the emergency medication delivery system as it was not available on the medication cart. Nurse #6 stated she was told by someone, unable to recall who, after she gave the dose from the emergency medication delivery system that she was not to do so since it was not the correct dose. The emergency medication delivery system contained gabapentin 100 mg tablets and Resident #46's physician order was for 800 mg. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart and she did not obtain it from the emergency medication delivery system on 5/12/24 or 5/13/24. Nurse #6 stated she was not aware of the process for obtaining a medication that was not available.

An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse # 17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated she looked for the medication on the medication cart and when she did not see it, she documented it 9, not available. Nurse #17 indicated medications were frequently missing and ran out from the medication cart. Nurse #17 stated she did not notify the pharmacy or the provider that the medication was not available. Nurse #17 revealed gabapentin was prescribed for pain and Resident #46 exhibited increased pain, irritability

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and anxiety from not receiving the medication.

An interview was conducted on 6/13/24 at 3:47 PM with Nurse #16. Nurse #16 was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24 from 7:00 PM to 7:00 AM. Nurse #16 stated 9 on the electronic MAR indicated the medication was not available. Nurse #16 indicated she documented "9" for unavailable on Resident #46's MAR on 5/13/24, 5/14/24 and 5/15/24 at 9:00 PM for the scheduled dose of gabapentin. Nurse #16 stated gabapentin was not on the medication cart for Resident #46, Nurse #16 stated she worked at the facility through an agency for about 6 weeks. Nurse #16 stated medications were frequently missing from the medication cart. Nurse #16 stated she did not call the pharmacy to obtain the medication. Nurse #16 stated gabapentin was prescribed for pain and not receiving the medication caused Resident #46 increased pain.

An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 stated she signed for the dose on the electronic MAR on 5/15/24 at 9:00 AM in error. Nurse #7 recalled gabapentin was not available on the medication cart, but she did not attempt to obtain it or notify the physician. Nurse #7 stated Resident #46 was upset and had increased pain when she did not receive the ordered gabapentin. Nurse #7 stated she was aware that gabapentin was prescribed for nerve pain and not receiving the medication would cause the resident to have

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increased pain and should be monitored for this. Nurse #7 was unaware of the process for obtaining a medication that was not available.

An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she thought a written or electronic prescription was required to obtain a refill of gabapentin. Unit Manager #2 stated there had been delays in receiving refills of gabapentin, but she did not know why and Resident #46 had gone without the medication. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered, resident had increased pain and she did not attempt to obtain it. Unit Manager #2 stated she did nothing about Resident #46's medication not being available.

An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated there was a problem with running out of medications and medications not being available. Nurse #5 stated she used the computer to reorder medications, but they frequently did not come in and she did not know why. Nurse #5 stated administration was aware of the problem with medication not coming in from pharmacy. Nurse #5 stated she did not know if a written or electric prescription was needed to reorder gabapentin. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM, did not call the pharmacy to obtain the medication and observed Resident #46 to have increased pain which was abnormal for the resident. Nurse #5 stated she

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the medication was on order, so she did not attempt to obtain it.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the prescribed dose for Resident #46 on 5/17/24 and resident had increased pain. Nurse #2 stated she did not call the pharmacy to obtain the prescribed gabapentin for Resident #46. Nurse #2 stated medications were frequently unavailable, and she was informed by other nurses, although she did not recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done.

Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM. Messages were left on 6/11/24 and 6/12/24 with no return call received.

An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated the facility had trouble obtaining medications. Resident #46 stated she had gone without medications for days at a time on several occasions. Resident #46 reported staff stated the medication was coming from the pharmacy and then it didn't come in. Resident indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not receive her gabapentin. Resident #46 stated it was horrible and the staff told her she would just have to wait it

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out until the medication came in.

Review of a 5/27/24 Medication Record Review by the Consultant Pharmacist indicated a medication error was identified in Resident #46's electronic health record. The note indicated gabapentin was marked out of stock for 13 doses in May 2024. The Pharmacist indicated on the note that she checked the pharmacy records and found the pharmacy sent a 30-day supply of the medication gabapentin on 5/6/24. Communication was sent to the facility on 5/11/24 and 5/16/24 that the medication was filled on 5/6/24 and would be refilled again on 5/30/24. Please review with staff.

An interview was conducted by phone with the Pharmacy Quality Assurance (QA) Specialist on 6/12/24 at 11:50 AM. The Pharmacy QA Specialist indicated the pharmacy treated gabapentin as a controlled medication in terms of the storage and accounting for it. She stated a written or electronic prescription was not required to obtain the medication from the pharmacy. The Pharmacy QA Specialist stated the process for obtaining a refill of the medication gabapentin was the facility faxed the refill sticker or completed a refill request in the computer. The Pharmacy QA Specialist indicated the supply of gabapentin for Resident #46 was returned to the pharmacy on 5/6/24 with the delivery driver however the delivery sheet was not placed in the folder for follow up so the pharmacy technician did not investigate the problem the next day per the usual process nor was another supply sent to the facility. The Pharmacy QA Specialist stated the pharmacy was not aware until an investigation was completed on 5/17/24 regarding Resident #46's supply of gabapentin that was returned on

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5/6/24. The pharmacy received refill requests from the facility for gabapentin for Resident #46 on 5/11/24 and 5/16/24. Communication was sent via fax to the facility on 5/11/24 and 5/16/24 indicating it was too early to obtain a refill of gabapentin for Resident #46. When the facility did not respond to the faxed communication regarding the refill requests, the pharmacy investigated, found that the 5/6/24 supply of gabapentin was returned and then sent a replacement supply.

An interview was conducted by phone with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist indicated there was a system process problem with the ordering and reordering of medications in the facility. In March when the current Director of Nursing (DON) started, the Consultant Pharmacist stated she held a meeting with the DON to discuss the problem of ordering and reordering of medications for administration. Following the meeting, the pharmacy provided new fax machines for the facility to alleviate the problem of faxes not being received, however the problem continued. The Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate). The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe. The Consultant Pharmacist indicated the pharmacy considered gabapentin a controlled medication for storage and accounting purposes but did not require a written or electronic prescription for refills.

An interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON

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stated she did not know why the medication gabapentin was not available for Resident #46. The DON stated a system was required in the facility to track medication refills and to ensure medications were received prior to the supply being depleted.

A follow up in-person interview with the Director of Nursing (DON) on 6/12/24 at 4:15 PM revealed the nurses on the medication cart were expected to reorder medications within 5-7 days of the supply being depleted. The DON stated she was aware Resident #46 did not receive Gabapentin 800 mg twice per day from 5/10/24 through 5/17/24. The DON stated she started at the facility at the end of March 2024, and did not recall when she became aware Resident #46 did not receive the ordered gabapentin. The DON stated there had been problems with the fax machines in the facility for a while and that may have contributed to the problem. The DON expected medications were available for residents as ordered.

An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected that medications would be available and administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identified a medication was not available for administration. The Administrator stated there were problems with the fax machines in the facility and that had affected communication between the facility and the pharmacy.

An interview was conducted by phone with the Physician on 6/18/24 at 1:20 PM. The Physician

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indicated the dose of gabapentin ordered, 800 mg twice per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the risk of withdrawal and increased pain. Withdrawal symptoms can occur within 12 hours and can be severe. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered. The Physician further indicated it was not right to withhold medication from a resident and it had the potential for adverse outcome. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered.

The Administrator was notified of Immediate Jeopardy on 6/13/24 at 2:15 PM.

The facility provided the following Immediate Jeopardy removal plan:

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

The facility failed to ensure routine pain medication was obtained and available for administration (Resident #51 and Resident #46).

The facility failed to ensure routine pain medication was obtained and available for administration (Resident #51). Resident #51 had a routine order for gabapentin 800 mg 4 times a day. The medication was not available for administration. This resulted in the resident not receiving the medication gabapentin as ordered for 21 administrations. The pharmacy sent a supply of 120 pills on 04/25/2024. Resident #51 was in the hospital from 05/05/2024 through the

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morning of 05/08/2024. The supply of medicine was sent back to the pharmacy while she was in the hospital. The order was unchanged when she returned to the facility on 05/08/2024. The pharmacy sent a 30-day supply (120 pills) on the night of 05/13/2024.

Resident #51 complained of pain. On 05/09/2024 Resident #51 refused a shower due to too much pain. On 05/10/2024 Resident #51 complained of her legs feeling numb. On 05/12/2024 Resident #51 complained of pain and spasming in which Resident #51 requested to go to the Emergency Room (ER). Resident #51 returned from the ER where the resident was treated for acute pain and received gabapentin at the hospital. In the evening on 05/12/2024 Resident #51 complained of agitation and anxiety due to not receiving gabapentin and requested to go to the ER. Resident #51 received gabapentin in the ER. The physician in the ER sent a new prescription for gabapentin to the pharmacy.

The facility further failed to ensure routine pain medication was obtained and available for administration (Resident #46). Resident #46 had a routine order for gabapentin 800 mg 2 times daily. The medication was not available for administration. This resulted in the resident not receiving the medication as ordered. Resident #46 had a pain level of 8 or 9 constantly during the time the facility failed to obtain and administer the medication. Resident #46 complained of not receiving pain medication which caused her more pain and made it hard to sleep. Resident #46 complained of irritability, being anxious, and nausea. Resident #46 had not felt well and had not been able to get out of bed to participate in activities and perform a daily routine due to pain

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in her legs. The facility failed to obtain and administer a total of 14 doses of gabapentin between 05/10/2024 and 05/17/2024.

On 06/13/2024 the Administrator and Director of Nursing consulted with the facility Consultant Pharmacist to further investigate the medication delays during 05/08/2024 - to 05/17/2024. It was determined by the Consultant Pharmacist that the pharmacy had made an error and not shipped the medication in a timely manner. It was further determined that nursing staff do not have a comprehensive understanding of what to do when they identify that a medication is not available for administration.

On 06/13/2024 the Director of Nursing and Unit Managers (UMs) began to complete an audit for the past 90 days of all residents in the facility with pain medication orders to identify if there were any additional medications that needed to be ordered. The purpose of this audit is to ensure all pain medications are in the facility and available for administration. This will be completed by 06/15/2024. If there are any concerns identified, the concerns will be reported to the physician immediately to ensure the facility is effectively managing pain.

On 06/13/2024 the Director of Nursing and Unit Managers (UMs) began to complete an audit for all current residents in the facility with pain medication orders to ensure their pain medication is in the facility and available for administration. This will be completed by 06/15/2024. If there are any concerns identified, the concerns will be reported to the physician immediately and the pain medication will be ordered to ensure the facility is effectively managing pain.

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete:

On 06/13/2024 the Director of Nursing educated Floor Nurses and Unit Managers (UMs) on the daily medication refill log that is to be maintained by the Floor Nurses and UMs to ensure medications are obtained from the pharmacy in a timely manner to prevent further medication delays. Nurses will identify needed medications when they are completing medication cart audits. The nurse will identify the need for medication to be refilled and the refill should be requested by the pharmacy at least 7 - 10 days prior to the medication running out. The minimum amount of time depicted on the medication card is 5 days prior to the medication running out. The Director of Nursing and Unit Managers (UMs) will begin in person education on 06/13/2024 with all nurses and medication aides which will include all full-time, part-time, as needed, and agency staff. This education will be on the importance of providing medications per the physician's orders, ensuring appropriate medication is available for administration, and if the medication is not available the physician must be called for further treatment, guidance, and/or physician orders.

No nurses or medication aides will work after 06/13/2024 until they have received the education. The Director of Nursing will be responsible for keeping up with those nurses and medication aides who have and have not been educated. The Director of Nursing is responsible for completing the education or assigning the UM to complete the education for any staff who has

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not been educated by 06/13/2024. The UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure ordered medications are available for administration. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

All newly hired nurses and medication aides, (full-time, part-time, as needed, and agency) will be educated as noted above. This will be completed by the Director of Nursing. The Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Director of Nursing is responsible for completing the education with new hires. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

On 06/13/2024 the Director of Nursing and Consultant Pharmacist reviewed the facility pharmacy process. It was confirmed that the Director of Nursing will ensure all nurses and medication aides (full-time, part-time, as needed, and agency) have comprehensive knowledge on how to submit medication orders for residents. For future residents this process will include an assigned Floor Nurse faxing the discharge summary from the hospital to the pharmacy upon arrival at the facility. The Director of Nursing will assign a Floor Nurse to fax the discharge summary. The assigned Floor Nurse will enter any medications orders and clarify any questionable orders. If there is a controlled substance in the medication orders the discharging hospital will send a written copy of the prescription to the facility and the assigned

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Floor Nurse will fax the prescription to the pharmacy. The assigned Floor Nurse will make a copy for facility records and then the original prescriptions will be sent to the pharmacy that night with the pharmacy delivery driver.

Effective as of 06/13/2024 the facility process for refills of medications and newly prescribed medication will be the same process as previously noted. It is imperative the nursing staff recognize the need for a refill and anticipate the need. On 06/13/2024 the Director of Nursing will educate all nurses and medication aides (full-time, part-time, as needed, and agency) on the facility process for refills of medications and newly prescribed medication so the facility has an effective system in place to ensure ordered medications are available for administration. The Director of Nursing will educate nursing staff on how to put in a medication refill request. Nurses will access the resident's medication administration record from the electronic health record (EHR). The nurse will place an order for the prescribed medication by clicking on order or reorder whichever auto populates in the electronic health record (EHR), and the refill should automatically be sent to the pharmacy. If the ordered medication has not been received within 48 hours post order without any communication from pharmacy, the nurse will notify the UMs and the UMs will contact the pharmacy regarding the medication. When ordering a prescribed medication, the nurse should have written documentation in the nursing progress section of the EHR to read "refilled order processed" and have the confirmation, if any, should be included in the documentation. The UMs will record refill notifications with the information of the resident, product, strength,

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date and time of the refill notification. This will enable tracking of the system of ordered medications so that they are available in the facility for administration. The Director of Nursing is responsible for completing the education or assigning the UM to complete the education for any staff who has not been educated by 06/13/2024. The UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure ordered medications are available in the facility for administration. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

All newly hired nurses and medication aides (full-time, part-time, as needed, and agency) will be educated as noted above. This will be completed by the Director of Nursing. The Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Director of Nursing is responsible for completing the education with new hires. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator.

Alleged immediate jeopardy removal date: 06/16/2024

The removal plan of the Immediate Jeopardy was validated on 06/19/24. A sample of staff including the Administrator, Unit Manager, nurses, and medication aides were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding ensuring the nurse

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clarifies orders, enters the orders in the electronic medical record, faxes the discharge summary orders from the hospital to the pharmacy, and the process for completing a medication refill request. Observation of nursing staff was conducted to ensure they understood how to enter orders in the electronic record and receive confirmation that the refilled order was processed. Additionally, the nursing staff explained the process of utilizing the refill log. Staff reported when the medication card had a remainder of 5 doses indicated in the blue section of the medication care, then an order for a refill was entered in the electronic record. The drug information was also handwritten on the refill request form to include the name of resident, name of drug, the required dose, and the administration frequency. This form was kept on the medication cart in the narcotic book. The second shift nurse received the medications that were ordered from the pharmacy each night. That nurse was to make sure what was ordered on the refill request form was delivered. The Unit Manager reviewed the refill request form each morning to ensure the refill orders were processed. If there were any discrepancies, the Unit Manager would be responsible for notifying the pharmacy within 48 hours as to the status of the medication. The medication refill request form was reviewed, and audits were conducted. The IJ removal date of 06/16/24 was validated.
3. Resident #8 was admitted to the facility on 8/19/23 with diagnoses which included chronic atrial fibrillation, Type 2 Diabetes Mellitus, and arthritis pain.

Review of the Resident #8's physician orders revealed an 2/28/24 order for Oxycodone/Acetaminophen 10/325 milligrams (mg) - 1 tablet by mouth two times a day at 8:00

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am and 8:00 pm for pain, Oxycodone/Acetaminophen 5/325 mg - 1 tablet by mouth once a day at 2:00 pm for pain, and Bio Freeze Professional External Gel 5% topical analgesic apply to area every 6 hours as needed for pain (PRN).

A review of the pharmacy records indicated 30 tablets of Oxycodone/Acetaminophen 10/325 mg was delivered to the facility on 3/28/24 and signed by Nurse #10 and Nurse #18.

The April 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 10/325 mg was scheduled to be administered at 8:00 am and 8:00 pm and specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #8's Oxycodone/Acetaminophen:

4/16/24
- The MAR for 8:00 pm indicated Nurse #2 documented a "9" and there was no corresponding nursing note.
4/18/24
- The MAR for 8:00 am indicated Nurse #6 documented a "9" and the corresponding record note at 9:06 am indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
- The MAR for 8:00 pm indicated Nurse #9 documented a "9" and the corresponding record note at 9:36 pm indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
4/19/24
- The MAR for 8:00 am indicated Nurse #9

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documented a "9" and the corresponding record note at 12:53 pm indicated Resident #8 was out of the facility with spouse and friend for lunch.
- The MAR for 8:00 pm indicated Nurse #8 documented a "9" and the corresponding record note at 8:42 pm indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
4/20/24
- The MAR for 8:00 am indicated MA# 5 documented a "9" and there was no corresponding nursing note.
4/21/24
- The MAR for 8:00 am indicated MA# 5 documented a "9" and there was no corresponding nursing note.
4/22/24
- The MAR for 8:00 am indicated Nurse #6 documented a "9" and the corresponding record note at 9:34 am indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
- The MAR for 8:00 pm indicated Nurse #8 documented a "9" and the corresponding record note at 8:53 pm indicated the medication was on order.
4/23/24
- The MAR for 8:00 am indicated Nurse #19 documented a "9" and the corresponding record note at 9:46 am indicated the medication was not on hand and had been ordered.
- The MAR for 8:00 pm indicated Nurse #8 documented a "9" and the corresponding record note at 8:38 pm indicated the medication was on order from the pharmacy.
4/24/24
- The MAR for 8:00 am indicated Nurse #9 documented a "9" and there was no corresponding nursing note.

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A review of the facility's narcotic count sheet (a document used to document and track the administration of controlled substances) for Resident #8's Oxycodone/Acetaminophen 10/325 mg revealed no nurse signatures for the following:

- 4/16/24 8:00 pm Nurse #2
- 4/18/24 8:00 am Nurse #6
- 4/18/24 8:00 pm Nurse #8
- 4/19/24 8:00 am Nurse #9
- 4/19/24 8:00 pm Nurse #8
- 4/20/24 8:00 am MA #5
- 4/21/24 8:00 am MA# 5
- 4/22/24 8:00 am Nurse #6
- 4/22/24 8:00 pm Nurse #8
- 4/23/24 8:00 am Nurse #19
- 4/23/24 8:00 pm Nurse #8
- 4/24/24 8:00 am Nurse #9

Attempts were made to interview Nurse #9 via phone with messages left on 6/28/24 with no return call received. Nurse #9 no longer worked at the facility.

Attempts were made to interview Nurse #2 by phone with messages left on 6/28/24 with no return call received. Nurse #2 worked at the facility through an agency.

Attempts were made to interview Medication Aide #5 (MA #5) by phone with messages left on 6/28/24 with no return call received.

During a phone interview on 7/1/24 at 11:51 am with Nurse #8, she indicated Resident #8 did not have her scheduled 8:00 pm Oxycodone 10/325

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F 755	Continued From page 202 mg available on 4/19/24 and 4/23/24. She indicated in her nursing documentation she was awaiting delivery from the pharmacy. She stated she did not know which nurse ordered the Oxycodone 10/325 mg. During a phone interview with Pharmacy Tech #1on 7/1/24 at 3:32 pm she stated the pharmacy sent the narcotics (Oxycodone/Acetaminophen) on 3/28/24. The Pharmacy Tech #1 indicated not enough Oxycodone/Acetaminophen was sent for Resident #8. She further stated the facility did not request a refill for the medication after 3/28/24 and prior to 4/25/24.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		7/27/24

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F 756	Continued From page 203 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with Consultant Pharmacist, Physician, and staff, the facility failed to act on pharmacy recommendations for 7 of 10 residents (Resident #39, Resident #18, Resident #50, Resident #47, Resident #22, Resident #46 and Resident #8) reviewed for medications. Findings included: 1. Review of the hospital discharge summary dated 05/02/24 for Resident #39 revealed the following physician order: Amoxicillin-Clavulanate 875 MG (Milligram)-125 MG oral one tablet every 12 hours for 7 days for diagnoses of sepsis related to a perirectal abscess and a urinary tract infection (UTI). Resident #39 was admitted to the facility on 05/02/24 with a diagnosis of a UTI.	F 756	The facility failed to act on pharmacy recommendations for 7 of 10 residents (Resident #39, Resident #18, Resident #50, Resident #47, Resident #22, Resident #46 and Resident #8) reviewed for medications. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee will review all pharmacy recommendations from, June of 2024, by 8/5/2024 to ensure all pharmacy recommendations are approved by the provider and changes are updated. The DON will review pharmacy recommendations for Resident #39, Resident #18, Resident #50, Resident	

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F 756	Continued From page 204 Review of the physician orders for Resident #39 revealed the following order was entered into the computer system on admission: Amoxicillin 875 MG give 1 tablet by mouth every 12 hours for UTI for 7 days. Review of an admission Minimum Data Set (MDS) assessment dated 05/08/24 revealed Resident #39 had intact cognition. He had an indwelling urinary catheter. He was administered antibiotic medications. Review of the facility MAR (Medication Administration Record) for May 2024 revealed Resident #39 was administered Amoxicillin 875 MG on 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/07/24, 05/08/24, 05/09/24, and 05/10/24 for a total of 14 doses. Review of the Consultant Pharmacist ' s Medication Regimen Review dated 05/27/24 revealed the following recommendation as a "Priority: High": "This resident was admitted with an order for Amoxicillin/Clavulanate 875 MG BID [twice a day] for 7 days. This was entered into the computer as Amoxicillin 875 MG. This is what the pharmacy sent. Please notify the provider of the medication error to clarify if any additional treatment is needed. Please review with the nurses to ensure they read orders carefully and double check entries." There was no documentation that this pharmacy review was reviewed by nursing or the physician. In an interview with the Consultant Pharmacist on 6/12/24 at 9:50 AM she stated the difference between Amoxicillin and Amoxicillin-Clavulanate was that the addition of Clavulanate helped the Amoxicillin work better and more types of bacteria	F 756	#47, Resident #22, Resident #46 and Resident #8 by 8/5/2024 to ensure that the pharmacy recommendations for each resident have been acknowledged and addressed with the provider. The DON or Designee will educate all nursing managers by 8/5/2024 on the procedure for completing all pharmacy recommendations, to include obtaining approval from the provider, as well as communicating with contracted providers as necessary, to ensure all orders are followed. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will audit all incoming pharmacy recommendations monthly for 12 months to ensure all orders are up to date according to the pharmacy recommendations. Any missing order changes will result in re-education and additional training for the appropriate nursing staff. The DON or Designee will audit all pharmacy recommendations monthly for 12 months to ensure the pharmacy recommendations are approved by the provider and any changes are updated. Any missing approvals by the provider will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the	

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F 756	Continued From page 205 were affected. She would have expected the provider to be notified to report the medication error and determine if additional treatment was necessary. During an additional interview on 06/26/24 at 1:17 PM with the Consultant Pharmacist she explained during a monthly review before she left the building, she emailed the complete pharmacy report and recommendations to the Agency Director of Nursing (DON). Routinely, she expected recommendations to be addressed before she returned to complete the next monthly review. If she found a recommendation had not been addressed, she would write another recommendation and speak to the DON directly to try and get the recommendation addressed. This recommendation was identified as "Priority: High" on the Medication Regimen Review and she would have expected the Agency DON to call the physician when she received the report to determine if any additional treatment was needed. In an interview with the current Agency DON on 06/12/24 at 4:40 PM she stated she had not followed up on the pharmacy recommendation and had not notified the provider that the wrong antibiotic had been administered to Resident #39 to determine if further treatment was necessary. She stated she had been aware of the recommendation and was responsible for acting on the recommendation when it was received in May 2024. In an interview with the facility's current physician on 06/19/24 at 9:30 AM she stated she had not been notified that Resident #39 was given the wrong antibiotic. She noted she had just started	F 756	results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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at the facility last week and was not his doctor when this occurred. However, she reported she had seen Resident #39 yesterday and he was not having any symptoms of a UTI at this time. She did not feel any further intervention was required. She stated she would expect to be notified whenever there was a pharmacy recommendation on her next routine visit to the facility or called if the situation required immediate attention.

2. Resident #18 was admitted to the facility most recently on 06/23/23.

Diagnoses included a generalized anxiety disorder.

The physician order for Resident #18 dated 11/08/23 indicated Ativan (antianxiety medication) 0.5 mg every 6 hours as needed for anxiety or agitation. This order had no stop date.

Review of a pharmacy recommendation titled, "Note to Attending Physician/Prescriber", dated 04/25/24, documented: "CMS [Centers for Medicare and Medicaid Services] regulations state that PRN [as needed] psychotropics can only be given x 14 days. If the resident requires a PRN psychotropic after 14 days, the physician must provide rationale and indicate the duration for the PRN order. Hospice is not exempt."

Review of a quarterly Minimum Data Set (MDS) assessment dated 05/13/24 revealed Resident #18 had moderately impaired cognition. She received Hospice services and had a life expectancy of less than six months. She did not receive antianxiety medication during this assessment look back period.

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The active physician orders for Resident #18 as of 6/12/24 indicated the PRN Ativan order initiated on 11/8/23 remained in place.

Review of the Medication Administration Record (MAR) from January 2024 through June 2024 for Resident #18 revealed PRN Ativan had been administered on 01/27/24, 04/09/24 and 04/23/24.

In an email received on 6/26/24 at 3:23 pm from the Consultant Pharmacist she explained she had notified the facility through pharmacy recommendations month after month on 12/19/23, 1/26/24, 2/18/24, 3/25/24, 4/25/24 and 5/27/24 to discontinue the PRN psychotropic Ativan or provide a rationale and indicate the duration for the medication. She wrote that she had communicated to the previous DON every month that the report had medication issues that were urgent and needed to be addressed. She also spoke with the previous DON monthly regarding the pharmacy reports. She stated the previous DON never had the reports available when she spoke with her. She had emailed the current Agency DON on 4/29/24 regarding the PRN Ativan order, spoke with her in person in May 2024 and sent her another email on 05/28/24 regarding the Ativan order. She noted hospice was not exempt from this regulation.

In an interview with the current Agency DON on 06/13/24 at 4:33 PM she stated she was aware of the 14 day rule for PRN psychotropic medication. She stated she was aware of the pharmacy recommendations regarding the PRN Ativan but had not been able to communicate effectively with the previous physician to get the medication

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discontinued because there was a "personality conflict" between them. She stated she had not documented that attempts had been made to discontinue the medication and follow the pharmacy recommendation. She was aware the Consultant Pharmacist had made the request to discontinue the Ativan order in April and May 2024.

Multiple unsuccessful attempts were made on 06/12/14 at 1:50 PM and 3:33 PM to contact the previous physician. An additional attempt was made on 06/13/24 at 3:00 PM with no response. Other attempts were made to contact the physician by different surveyors on the team throughout the survey week with no response.

In an interview with the facility's current physician on 06/19/24 at 9:30 AM she stated she started working at the facility last week. She was aware of the 14 day rule for PRN psychotropics that applied even if the resident was on hospice services. She was not aware the Consultant Pharmacist had recommended the medication be stopped or reviewed with justification and given a stop date. She expected the facility to notify her of pharmacy recommendations and of PRN psychotropic medications that did not have a stop date during her routine visits to the facility or to be called if a recommendation needed immediate attention.

3. Resident #50 was admitted to the facility on 10/06/23. Diagnoses included, in part, coronary artery disease, high blood pressure, chronic kidney disease, and congestive heart failure.

A review of a physician's order written on 10/06/23 revealed give one tablet of Carvedilol (a

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medication to treat coronary artery disease) 12.5 milligrams twice daily and to hold medication for a heart rate less than 60 beats per minute (bpm) or systolic blood pressure (SBP) less than 110 milligrams per mercury (mg/Hg) and administer with meals.

A review of Resident #50's medication administration record (MAR) for May 2024 to administer the Carvedilol 12.5 milligrams revealed the following:

05/11/24 the blood pressure recording was 100/59 mm/Hg and the heart rate recording was 59 bpm at 9:00 AM and was signed off by Unit Manager #1
05/15/24 the blood pressure recording was 106/68 mm/Hg at 9:00 AM and was signed off by Nurse #9
05/26/24 the blood pressure recording was 109/63 mm/Hg at 5:30 PM and was signed off by Unit Manager #1
05/27/24 the blood pressure recording was 103/69 mm/Hg at 5:30 PM and was signed off by Unit Manager #1

Review of the Consultant Pharmacist's medication regimen reviewed from 05/01/24 through 05/27/24 revealed "this resident has order to hold Carvedilol for SBP less than 110 or heart rate less than 60. This dose was not held as ordered. Please report medication error and review with nurses."

An interview was conducted with the Pharmacist Consultant on 06/11/24 via phone at 11:20 AM. The Pharmacist Consultant stated when she completed her medication regimen review she would email the Director of Nursing (DON) the

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review within a day after she finished her review. She added, she would expect the DON to review the regimen to address any high risk medication concerns right away. The Pharmacist Consultant stated a blood pressure medication is a high risk medication and if there were parameters given in an order, the expectation was that the blood pressure medication would be held according to the physician's order if the reading was outside the parameters. She stated the resident would be at risk for increased hypotension (low blood pressure) or bradycardia (decreased heart rate) if the medication was given.

An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 5:00 PM. The DON stated the Pharmacist Consultant sent her the May pharmacy recommendations when she had finished. She stated she did not know the actual date she received it in May. She stated as of this date, she had not reviewed all of the May's pharmacy recommendations and had not notified the physician about the medication error that occurred and she should have addressed this recommendation since it was a high risk medication and warranted attention as soon as possible.

A phone interview with the facility Physician on 06/19/24 at 9:30 AM revealed she would have expected to be notified whenever there was a medication error so the error could be addressed when it occurred.

4. Resident #47 was admitted to the facility on 12/13/21 with diagnoses including a bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows) and schizophrenia (a serious

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mental health condition that affects how people think, feel and behave).

Resident #47's electronic medical record (EMR) revealed the last assessment for Abnormal Involuntary Movement Scale (AIMS), a scale that measures the severity of involuntary movements caused by neuroleptic medications (medications known for their ability to attenuate hallucinations and delusions), was dated 11/06/2023 and reported Resident #47 was not experiencing involuntary movements, an adverse side effect to psychotropic medications.

A review of Resident #47's EMR included a physician order dated 2/24/2024 Ingrezza (a medicine that treats body movement disorders) 80 milliigrams (mg) at bedtime for tardive dyskinesia (a drug induced movement disorder that causes involuntary facial tics), and a physician order dated 3/27/2024 for Ziprasidone HCL (an antipsychotic medication used to treat bipolar disorders and schizophrenia) 80 mg twice a day for bipolar disorder.

The monthly Medication Regimen Review (MRR) dated 5/25/24 conducted by the Consultant Pharmacist revealed a recommendation for an AIMS assessment for Resident #47.

A review of the May and June 2024 Medication Administration Records (MARs) indicated Resident #47 had received the medications Ingrezza and Ziprasidone HCL daily as prescribed by the physician.

In a phone interview with the Consultant Pharmacist on 6/12/2024 at 10:44 am, she explained AIMS assessments were to be

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completed on residents receiving antipsychotics every six months, and she communicated the pharmacy recommendations for a AIMS assessment for Resident #47 through an email to the Director of Nursing (DON) on 5/25/2024.

In an interview with Unit Manager #1 on 6/14/2024 at 11:18 am, she stated pharmacy recommendations were sent to the Director of Nursing (DON), and she had not received a pharmacy recommendation for Resident #47 to receive an AIMS assessment from the DON. She stated there was a communication gap between the DON and herself and understood recommendations not received were left on the fax machine, shredded or lost. She explained AIMS assessments should automatically populate in the EMR for nurses to complete, and she was not aware Resident #47 needed an AIMS assessment

In an interview with the Director of Nursing on 6/12/2024 at 10:04 am, she explained due to experiencing internet outages in May 2024, she had not reviewed the May 2024 pharmacy recommendation for Resident #47. When asked why AIMS assessment had not been completed, the DON explained AIMS assessments were generated through the EMR and stated she had just learned how to migrate this information to the EMR. She said she had not provided the unit managers training on the process of adding AIMS assessments as she was planning a training for the week this recertification survey began.

5. Resident # 22 was readmitted to the facility on 06/22/23.

Review of Resident #22's electronic health record

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revealed a diagnoses report which included a diagnosis of generalized anxiety disorder.

Review of the physician orders for Resident #22 revealed an order dated 3/7/24 for Ativan 0.5 milligrams (mg) give one tablet via gastrostomy tube (a tube surgically placed in the abdomen to provide nourishment, liquids and medications) every 8 hours as needed for anxiety.

Review of the March 2024 MAR for Resident #22 revealed on 3/21/24 the resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

Review of a quarterly MDS assessment dated 3/29/24 revealed Resident # 22 had moderately impaired cognition and received an antianxiety medication.

Review of the April 2024 MAR for Resident #22 revealed on 4/5/24 the resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

Review of the May 2024 MAR for Resident #22 revealed on 5/12/24 and 5/21/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

Review of Resident # 22's electronic health record revealed a Consultant Pharmacist recommendation titled Note to Attending Physician/Prescriber dated 5/27/24 which indicated in part: the resident had an order for a PRN psychotropic medication and Hospice is not exempt. If the resident requires a PRN psychotropic after 14 days, the physician must provide rationale and indicate the duration for the PRN order. The note was checked to continue

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Ativan PRN x 90 days with a rationale of Hospice. The note was signed by the previous Physician on 5/30/24.

Review of the June 2024 MAR for Resident #22 revealed on 6/3/24, 6/16/24 and 6/23/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

In an interview with the Consultant Pharmacist on 06/12/24 at 9:15 AM she stated she notified the facility through a pharmacy recommendation to discontinue the PRN psychotropic medication or provide a rationale and indicate the duration for the medication. The Consultant Pharmacist stated residents receiving Hospice services were not exempt from this regulation. The Consultant Pharmacist indicated there had been problems in the facility under the previous Director of Nursing with the recommendations not being addressed. The Consultant Pharmacist stated when she completed her medication regimen review, she emailed a copy of her review to the Director of Nursing (DON) within a day after she finished. The Consultant Pharmacist stated she expected the DON to review the medication regimen review and address the recommendations right away.

Attempts were made via phone to interview the previous Physician on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with messages left. No return call was received.

In an interview was conducted with the current Director of Nursing (DON) on 06/13/24 at 4:33 PM. The DON stated she was in the position at the facility since the end of March 2024. The DON stated she was aware of the 14-day regulation for PRN psychotropic medication, and

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she was aware of the pharmacy recommendations but had not been able to communicate with the previous physician to get the medication discontinued. The DON indicated the Consultant Pharmacist sent her the recommendations via email after her monthly reviews were completed. The DON stated she was responsible for reviewing and addressing the Consultant Pharmacist recommendations. The DON stated she saw the 5/27/24 recommendation for Resident #22 and was aware that the previous physician indicated Hospice on the recommendation and did not provide a stop date or discontinue the as needed psychotropic medication. The recommendation was given to the previous physician to address but the DON indicated she had not had a conversation with him regarding this.

An interview was conducted with the current Physician via phone on 6/18/24 at 1:15 PM. The Physician stated she started working at the facility on 6/7/24 and was not familiar yet with the residents, their orders and the systems in the facility. The Physician stated she was aware of the 14-day regulation for PRN psychotropics and that this applied even if the resident was on Hospice services. She expected the facility to notify her of pharmacy recommendations, address the recommendations as indicated and notify her of an as needed psychotropic medication that did not have a stop date. The Physician stated she was not made aware the pharmacy had recommended Resident #22's medication be stopped or reviewed with justification and given a stop date.

6. Resident #46 was admitted on 12/6/23.

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Review of the electronic health record for Resident #46 revealed a diagnosis report which included the diagnosis of diabetes and diabetic nerve pain.

Review of the electronic health record for Resident #46 revealed a physician order dated 12/6/23 for gabapentin 800 milligrams (mg) twice per day for nerve pain.

Review of Resident #46's May Medication Administration Record (MAR) revealed the medication Gabapentin 800 milligrams (mg.) twice per day was recorded as "9" which indicated to see nursing administration progress notes for both scheduled doses on 5/10/24, 5/11/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24, 5/16/24, 5/17/24.

Review of Resident #46's electronic health record revealed administration notes were made on 5/12/24, 5/13/24, 5/16/24 and 5/17/24 which indicated awaiting pharmacy delivery of medication gabapentin.

Review of a 5/27/24 Medication Record Review by the Consultant Pharmacist indicated a medication error was identified in Resident #46's electronic health record. The note indicated gabapentin was marked out of stock for 13 doses in May 2024. Please review with staff.

An interview was conducted via phone with the Consultant Pharmacist on 6/12/24 at 9:15 AM. The Consultant Pharmacist stated when she completed her medication regimen review, she emailed a copy of her review to the Director of Nursing (DON) within a day after she finished. The Consultant Pharmacist stated she expected

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the DON to review the medication regimen review and address any medication errors right away.

An interview was conducted with the Director of Nursing (DON) on 6/13/24 at 4:33 PM. The DON was unable to explain any action that was taken as a result of the Consultant Pharmacist's report dated 5/27/24 that indicated a medication error had been made with Resident #46's gabapentin. The DON stated she had not reviewed the medication error with staff, nor had she completed a medication error incident report. The DON stated the Pharmacist Consultant sent her the May pharmacy recommendations after her review on 5/27/24. The DON stated she did not know the actual date she received it in May. The DON stated as of this date, she had reviewed some of the May pharmacy recommendations but not all of them and she had not notified the physician about the medication error that occurred. The DON indicated she should have addressed this recommendation and that she was responsible for reviewing the pharmacy recommendations.

An interview was conducted with the current Physician via phone on 6/18/24 at 1:15 PM. The Physician stated she started working at the facility on 6/7/24. The Physician stated she expected the facility to notify her of pharmacy recommendations. The Physician further stated that all pharmacy recommendations that indicated a medication error occurred should be addressed to ensure that the error does not occur again.

7. Resident #8 was admitted to the facility on 8/19/23 with diagnoses which included chronic atrial fibrillation, Type 2 Diabetes Mellitus, and pain.

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A review of Resident #8's electronic medical record (EMR) included the following physician orders:
9/22/23: Ozempic 0.25 or 0.5 mg - inject 1 mg subcutaneously one time a day every Friday for type 2 Diabetes Mellitus
8/19/23: Rivaroxaban 5 mg - 1 tablet by mouth in the evening for atrial fibrillation
8/19/23: Glipizide 10 mg - 1 tablet by mouth two times a day for type 2 Diabetes Mellitus

A Pharmacy Consultant Medication Regimen Review (MRR) report dated 5/26/24 read "Ozempic weekly dose marked out of stock x 2 doses in April and 1 in May. That is 3 weeks without medication" and 6:00 pm meds Montelukast, Rivaroxaban (considered significant med error), Zotrix, Glipizide (significant med error) not charted 6 days so far in May". The pharmacist consultant recommended reporting the errors and reviewing with the nurses.

In an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am, stated she was aware of the Pharmacist Consultant Medication Regimen Review (MRR) dated 5/24/24 and did not ignore it. She further stated she felt this report was incorrect and therefore she did not report the medication errors or review the errors with the nurses.

During a phone interview with the Pharmacy Consultant on 6/12/24 at 10:15 am revealed the medications were available during April, May and June 2024 and indicated there was a systemic problem with medication administration. She further stated she discussed the problems with medications with the current Director of Nursing

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F 756	Continued From page 219 (DON) and made her aware of the concerns. She indicated her concerns regarding Resident #8's omissions of the ordered medications was hyperglycemia, increased risk for formation of blood clots, and increased pain.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		7/27/24

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F 758	Continued From page 220 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and Consultant Pharmacist, staff and Physician interviews the facility failed to limit an as needed (PRN) psychotropic medication to 14 days (Resident #18 and Resident #22), provide an appropriate diagnosis for an antipsychotic medication (Resident #269), and monitor for abnormal involuntary movements on a resident receiving an antipsychotic medication (Resident #47) for 4 of 5 residents reviewed for unnecessary medications. Findings included: 1. Resident #18 was admitted to the facility most recently on 06/23/23. Diagnoses included, in part, generalized anxiety disorder. Review of the physician orders for Resident #18 revealed the following order that started on	F 758	The facility failed to limit an as needed (PRN) psychotropic medication to 14 days (Resident #18 and Resident #22), provide an appropriate diagnosis for an antipsychotic medication (Resident #269), and monitor for abnormal involuntary movements on a resident receiving an antipsychotic medication (Resident #47) for 4 of 5 residents reviewed for unnecessary medications. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will review all antipsychotic medication usage to ensure all PRN medications have a 14 day stop date, by 8/5/2024 to ensure all ordered	

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F 758	Continued From page 221 11/08/23: Ativan 0.5 mg (Milligram)-give one tablet by mouth every 6 hours as needed for anxiety or agitation. Review of the January 2024 MAR (Medication Administration Record) for Resident #18 revealed on 01/27/24 she had been administered PRN Ativan 0.5 mg that had a start date of 11/08/23. Review of the April 2024 MAR for Resident #18 revealed on 04/09/24 and 04/23/24 she had been administered PRN Ativan 0.5 mg that had a start date of 11/08/23. Review of a quarterly MDS assessment dated 05/13/24 revealed Resident #18 had moderately impaired cognition. She had received scheduled and as needed pain medications during the assessment look back period. She received Hospice services. In an interview with the Consultant Pharmacist on 06/12/24 at 9:50 AM she stated she had notified the facility through pharmacy recommendations month after month to discontinue this PRN psychotropic or provide a rationale and indicate the duration for the medication. She noted residents who received Hospice services were not exempt from this regulation. An additional interview was conducted with the Consultant Pharmacist on 06/26/24 at 1:17 pm. She had filed recommendations on 12/19/23, 01/26/24, 02/18/24, 03/25/24, 04/25/24, and 05/27/24 regarding the ongoing PRN Ativan order. Each month she communicated to the Director of Nursing (DON) that the pharmacy reports had medication issues that were urgent and needed to be addressed. She had spoke with	F 758	antipsychotic medications have appropriate diagnoses, and to ensure all AIMs assessments are completed and up to date. The DON will review all as needed (PRN) psychotropic medications for Resident #18, Resident #22, Resident #269, and Resident #47 by 8/5/2024 and will ensure the AIMs assessments for Resident #18, Resident #22, Resident #269, and Resident #47 have been completed by 8/5/2024. The DON or Designee will educate all nursing staff by 8/5/2024 on the requirements for PRN antipsychotic medications, as well as the importance of monitoring the side effects of the medications by completing the AIMs assessments as scheduled. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit antipsychotic usage 5 times per week x 12 weeks to ensure all PRN medications have a 14 day stop date, and to ensure all antipsychotic medications have appropriate diagnoses. The DON or Designee will also audit all AIMs assessments weekly to ensure all assessments are completed as scheduled for 12 weeks. Any missing stop dates and/or AIMs assessments will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home	

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F 758	Continued From page 222 the previous DON monthly through March 2024. She had emailed the Agency DON on 04/29/24 and in May she spoke with the Agency DON in person and sent an email on 05/28/24 regarding the use of the PRN Ativan. In an interview with the DON on 06/13/24 at 4:33 PM she stated she was aware of the 14 day regulation for PRN psychotropic medication, and she was aware of the pharmacy recommendations but had not been able to communicate with the physician who was the Medical Director at the time to get the medication discontinued because she stated he would not listen to her. She explained she had not documented any attempts to discontinue the medication. In an interview with the facility physician on 06/19/24 at 9:30 AM she stated she started working at the facility last week. She was aware of the 14 day regulation for PRN psychotropics that applied even if the resident was on Hospice services. She was not aware the pharmacy had recommended the medication be stopped or reviewed with justification and given a stop date. She expected the facility to notify her of pharmacy recommendations and of PRN psychotropic medications that did not have a stop date. 2. Resident # 22 was admitted to the facility most recently on 06/22/23. Review of the diagnosis report revealed Resident #22 had a diagnosis of generalized anxiety disorder. Review of the physician orders for Resident #22 revealed an order dated 3/7/24 for Ativan 0.5	F 758	Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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milligrams (mg) give one tablet via gastrostomy tube every 8 hours as needed for anxiety.

Review of the March 2024 MAR for Resident #22 revealed on 3/21/24 the resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

Review of a quarterly MDS assessment dated 3/29/24 revealed Resident # 22 had moderately impaired cognition and received an antianxiety medication. Resident #22 was not coded as received Hospice services.

Review of the April 2024 MAR for Resident #22 revealed on 4/5/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

Review of the May 2024 MAR for Resident #22 revealed on 5/12/24 and 5/21/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24.

Review of Resident # 22's electronic health record revealed a Note to Attending Physician/Prescriber dated 5/27/24 which indicated in part: the resident had an order for a PRN psychotropic medication and Hospice is not exempt. If the resident required a PRN psychotropic after 14 days, the physician must provide rationale and indicate the duration for the PRN order. The note was checked to continue Ativan PRN x 90 days with a rationale of Hospice. The note was signed as a telephone order by the previous Physician on 5/30/24.

Review of the June 2024 MAR for Resident #22 revealed on 6/3/24, 6/16/24 and 6/23/24 resident was administered PRN Ativan 0.5 mg that had a

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start date of 3/7/24.

In an interview with the Consultant Pharmacist on 06/12/24 at 9:15 AM she stated she notified the facility through a pharmacy recommendation to discontinue the PRN psychotropic medication or provide a rationale and indicate the duration for the medication. The Consultant Pharmacist stated residents receiving Hospice services were not exempt from this regulation.

Attempts were made via phone to interview the previous Physician on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with messages left. No return call was received.

In an interview was conducted with the Director of Nursing (DON) on 06/13/24 at 4:33 PM. The DON stated she was aware of the 14-day regulation for PRN psychotropic medication, and she was aware of the pharmacy recommendations but had not been able to communicate with the physician who was the Medical Director at the time to get the medication discontinued.

In an interview was conducted with the Physician via phone on 6/1824 at 1:15 PM. The Physician she stated she started working at the facility on 6/7/24. The Physician stated she was aware of the 14-day regulation for PRN psychotropics and that this applied even if the resident was on Hospice services. She expected the facility to notify her of pharmacy recommendations and of PRN psychotropic medications that did not have a stop date.

3. Resident #269 was admitted on 3/7/24.

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Review of Resident #269's diagnosis report in the electronic health record revealed a diagnosis of toxic encephalopathy (a neurological disorder caused by exposure to toxic substances).

Review of Resident #269's hospital discharge summary dated 3/7/24 indicated the resident was to receive haloperidol 2 tablets of 2 milligrams (mg) at bedtime.

Resident #269's admission physician orders entered in the computer system on 3/7/24 included haloperidol 20 mg at bedtime for mood. The dose of 20 mg was entered into the computer in error. The order was entered into the computer by the Previous Director of Nursing (DON).

Review of a Medication Regimen Review (MRR) dated 3/8/24 for Resident #269 indicated an admission review was completed with no pharmacy recommendations.

Review of Resident #269's March 2024 Medication Administration Record (MAR) revealed haloperidol 20 mg was scheduled to be administered at 8:00 PM. The MAR was blank on 3/7/24 for the scheduled 8:00 PM dose. The MAR revealed the medication was electronically signed as administered on 3/8/24, 3/9/24, 3/10/24, 3/11/24, 3/12/24, and 3/13/24.

Resident #269's admission Minimum Data Set (MDS) dated 3/14/24 indicated the resident was cognitively intact, exhibited no behavioral symptoms and had no diagnosis of a psychiatric or psychotic disorder.

The medical record indicated Resident #269 was

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sent to the emergency room on 3/14/24 and returned with orders to continue haloperidol 2 tablets of 2 mg at bedtime.

Review of Resident #269's physician orders revealed an order dated 3/14/24 for haloperidol 2 mg give 1 tablet at bedtime for mood. The order was entered by the previous DON and was discontinued on 3/15/24.

Review of the March 2024 MAR for Resident #269 revealed haloperidol 2 mg give 1 tablet at bedtime on 3/14/24 at 8:00 PM was documented with a "9" indicating to see nurses notes. Review of Resident #269's nursing progress notes revealed there was no corresponding note on 3/14/24 at 8:00 PM.

Review of Resident #269's physician orders revealed an order dated 3/15/24 for haloperidol 2 mg give 2 tablets at bedtime for mood.

Review of the March 2024 MAR for Resident #269 revealed haloperidol 2 mg give 2 tablets at bedtime for mood was administered on 3/15/24, 3/16/24, 3/17/24, 3/18/24 and 3/19/24.

Review of a nursing progress note dated 3/20/24 indicated Resident #269 was discharged home.

Review of a Home Discharge Plan of Care indicated dated 3/20/24 indicated haloperidol 2 mg take 2 tablets at bedtime for mood was included in the list of discharge medications.

An interview was conducted with the Physician on 6/11/24 at 1:15 PM. The physician stated she was in the position at the facility since 6/7/24. The Physician indicated antipsychotic

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medications including haloperidol were only to be prescribed for specific psychiatric diagnoses. The Physician further stated mood was not an appropriate indication for prescribing an antipsychotic medication and this should have been clarified with the provider when the order was written.

An interview was conducted with the Consultant Pharmacist on 6/12/24 at 9:15 AM. The Consultant Pharmacist indicated haloperidol was usually only prescribed in an acute setting with a major psychiatric diagnosis. The Consultant Pharmacist indicated mood was not an appropriate diagnosis for an antipsychotic medication. The Consultant Pharmacist stated the order for haloperidol should have been clarified upon admission on 3/7/24 and return from the emergency room on 3/14/24.

An interview was conducted via phone with the Pharmacy Quality Assurance Specialist on 6/12/24 at 11:50 AM. The Pharmacy Quality Assurance Specialist indicated the pharmacy did not receive the hospital discharge summary dated 3/7/24 for Resident #269. The Quality Assurance Specialist stated normally the pharmacist compared the discharge summary and the orders that were entered into the computer and would call the facility for clarification or to report discrepancies. The Pharmacy Quality Assurance Specialist indicated the pharmacist that completed the medication regimen review for Resident #269 on 3/8/24 was no longer employed by the pharmacy.

An interview was conducted with the previous Director of Nursing (DON) on 6/13/24 at 1:20 PM via phone. The previous DON stated she entered

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the orders for Resident #269 when he was admitted to the facility from the hospital on 3/7/24. The previous DON stated she entered the order for haloperidol with the incorrect dose. The previous DON indicated she was not aware mood was not an appropriate diagnosis for haloperidol.

In an interview with the DON on 06/13/24 at 4:33 PM she stated she had been in the position since the end of March 2024. The DON stated she was aware of the regulation for an appropriate diagnosis for psychotropic medication, but she was not in the position when Resident #269 was in the facility. The DON stated mood was not an appropriate diagnosis for an antipsychotic medication.

Attempts were made via phone to interview the previous Physician on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with messages left. No return call was received.

4. Resident #47 was admitted to the facility on 12/13/21 with diagnoses including a bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows) and schizophrenia (a serious mental health condition that affects how people think, feel and behave).

The last Abnormal Involuntary Movement Scale (AIMS), a scale that measures the severity of involuntary movements caused by neuroleptic medications (medications known for their ability to attenuate hallucinations and delusions), assessment dated 11/06/2023 in Resident #47's electronic medical record (EMR) reported Resident #47 was not experiencing involuntary movements, an adverse side effect to

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psychotropic medications.

The quarterly Minimum Data Set (MDS) dated 2/1/2024 indicated Resident #47 was cognitively intact and received antipsychotic (medications used to treat mental health conditions) medications on a regular basis.

A review of Resident #47's EMR included a physician order dated 2/24/2024 Ingrezza (a medicine that treats body movement disorders) 80 milligrams (mg) at bedtime for tardive dyskinesia (a drug induced movement disorder that causes involuntary facial tics), and a physician order dated 3/27/2024 for Ziprasidone HCL (an antipsychotic medication used to treat bipolar disorders and schizophrenia) 80 mg twice a day for bipolar disorder.

Resident #47's monthly Medication Regimen Reviews (MRRs) conducted by the Pharmacist Consultant on 5/25/24 revealed a recommendation for an AIMS assessment for Resident #47.

A review the May and June 2024 Medication Administration Record (MAR) recorded Resident #47 had received the medications Ingrezza and Ziprasidone HCL daily as prescribed by the physician.

In a phone interview with the Pharmacist Consultant on 6/12/2024 at 10:44 am, she explained AIMS assessments were to be completed on residents receiving antipsychotics every six months, and she communicated the pharmacy recommendations for a AIMS assessment for Resident #47 through an email to the Director of Nursing (DON) on 5/25/2024.

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F 758	Continued From page 230 In an interview with Unit Manager #1 on 6/14/2024 at 11:18 am, she stated the AIMS assessment for Resident #47 populated onto the EMR screen when due and she had not observed a message to complete an AIMS assessment or received the pharmacy recommendation for an AIMS assessment dated 5/25/2024 from the DON. In an interview with the Director of Nursing on 6/12/2024 at 10:04 am, she stated due to Resident #47 receiving antipsychotic medications the nursing staff should be completing an AIMS assessment every three months. When asked why an AIMS assessment had not been completed since 11/6/2023 the DON stated she had not reviewed Resident #47's pharmacy recommendation date 5/25/2024 for an AIMS assessment due to experiencing internet outages in May 2024. The DON explained she had just recently learned how to migrate the AIMS assessments to auto-populate on the EMR and stated she had not provided the unit managers training on the process of auto-populating the AIMS assessments due to the start of this recertification survey the week she planned the training.	F 758		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, Consultant Pharmacist, Pharmacy	F 760	The facility failed to prevent significant medication errors for 9 of 10 residents	7/27/24

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F 760	Continued From page 231 Quality Assurance Specialist, Physician, and Wound Clinic Physician, the facility failed to prevent significant medication errors for 9 of 10 residents reviewed (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8). Resident #269 was administered 6 doses of haloperidol (antipsychotic medication) 20 milligrams (mg) instead of the ordered dosage of 2 tablets of 2 mg at bedtime and was not administered carvedilol (a medication used to treat heart failure, high blood pressure and chest pain) for 25 of the ordered doses. Resident #269 experienced an elevated pulse and shortness of breath requiring Emergency Department (ED) evaluation on 3/14/24. Resident #51 was not administered 21 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/8/24 through 5/13/24 resulting in complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the ED twice on 5/12/24 where she was treated for acute pain with gabapentin and returned to the facility. Resident #46 was not administered 14 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/10/24 through 5/17/24 resulting in increased pain, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Resident #419 was not administered 6 doses of intravenous (IV) (delivered into the vein) Rocephin (antibiotic) and 7 doses of IV Daptomycin (antibiotic) for treatment of his infected stage 4 sacral (triangular bone at the	F 760	reviewed (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA) who became the LNHA at the facility in February 2024, recognized that the Director of Nursing (DON) that had been the DON for approximately 10 months was involved in the cited deficiency. The LNHA terminated the DON in March 2024 when the LNHA became aware and investigated this concern. The LNHA promoted the current, at that time, Minimum Data Set (MDS) Registered Nurse (RN) to the role of full-time DON who then resigned from the position and returned to the MDS RN position. The LNHA hired an agency DON who was identified to also be involved in the cited deficiency during her tenure of approximately 3 months at the facility from March 2024 to June 2024. The LNHA terminated the agency DON during extended survey on 6/19/2024. The LNHA hired an experienced non-contractual DON on 6/19/2024 to ensure future compliance. The facility has also hired nursing staff including RNs and LPNs to ensure future compliance. Resident #269 received 6 doses of Haldol 20 mg instead of the ordered dosage of 2	

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F 760	Continued From page 232 base of the spine) pressure ulcer. The resident was hospitalized on 4/5/24 and the 4/26/24 discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection). In addition, the facility: administered 14 doses of Amoxicillin (antibiotic) to Resident #39 instead of the ordered Amoxicillin-Clavulanate; did not administer 34 doses of Resident #32's ordered mirtazapine (antidepressant medication); did not administer 23 doses of Resident #10's ordered tetrabenazine prescribed for the treatment of tardive dyskinesia (involuntary movements such as tongue thrusting, rapid eye blinking, repetitive chewing, that can occur with long term psychotropic use); did not follow the parameters indicated in the physician's order for Resident #50's blood pressure medication resulting in 8 doses not administered as ordered; and did not administer 12 doses of Resident #8's Oxycodone/Acetaminophen (opioid pain medication), 3 doses of Ozempic (anti-diabetic medication), 1 dose of Glipizide (anti-diabetic medication), and 1 dose of Rivaroxaban (anticoagulant). Immediate Jeopardy began on: 3/14/24 for Resident #269 when haloperidol and carvedilol were not administered as ordered and the resident required ED evaluation due to shortness of breath and an elevated pulse; 5/9/24 for Resident #51 when gabapentin not being administered as ordered resulted in a 10 out of 10 pain scale; 5/12/14 for Resident #46 when gabapentin not being administered as ordered resulted in increased pain and difficulty sleeping, and on 3/15/24 for Resident #419 when the	F 760	tablets of 2 mg at bedtime. This resident also did not receive 25 doses of carvedilol, causing the resident to experience an elevated pulse and shortness of breath, requiring an ED evaluation on 3/14/24. Resident #51 missed a total of 21 doses of gabapentin 800 mg from 5/8/24 through 5/13/24, resulting in constant pain at a level 10 out of 10, numbness in her legs, and leg spasms. Resident # 46 missed 14 doses of gabapentin 800 mg from 5/10/24 through 5/17/24, resulting in increased pain, trouble sleeping, anxiety, irritability, nausea, and unable to complete her daily routine due to her pain in her legs. Resident #419 did not receive 6 doses of IV Rocephin and 7 doses of IV daptomycin for treatment of his stage 4 sacral pressure ulcer. Resident #39 received 14 doses of Amoxicillin instead of the ordered Amoxicillin-Clavulanate. Resident #32 missed 34 doses of Mirtazapine. Resident #10 missed 23 doses of tetrabenazine prescribed for the treatment of tardive dyskinesia. Resident #50 received 8 doses of the prescribed blood pressure medication without following the parameters ordered	

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resident's IV dislodged (came out of her vein) and the nurse was unable to restart the IV to administer the ordered antibiotic. Immediate Jeopardy was removed on 6/15/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Examples #5, #6, #7, #8, and #9 were cited at scope and severity "E".

Findings included:

1. Review of Resident #269's hospital discharge summary dated 3/7/24 indicated the resident was to receive haloperidol 2 tablets of 2 milligrams (mg) at bedtime for mood and carvedilol 12.5 mg twice per day.

Resident #269 was admitted on 3/7/24 with diagnoses which included congestive heart failure, atrial fibrillation and toxic encephalopathy (a neurological disorder caused by exposure to toxic substances).

Resident #269's admission physician orders entered on 3/7/24 included haloperidol 20 mg at bedtime for mood. The order was entered into the computer by the previous Director of Nursing (DON).

Resident #269's admission physician orders entered on 3/7/24 did not include carvedilol 12.5 mg as indicated in his hospital discharge summary.

by the provider.

Resident #8 missed 12 doses of oxycodone/acetaminophen, 3 doses of Ozempic, 1 dose of glipizide and 1 dose of rivaroxaban.

The DON or Designee will review all Medication Administration Records (MARs) for all residents to ensure there are no missing doses by 8/5/2024. All missing doses will be reported to the provider and documentation will follow to ensure compliance by 8/5/2024.

The DON or Designee will also review all residents receiving blood pressure medications by 8/5/2024 to ensure they include parameters to follow, as well as alert the nurses/med aides to obtain a blood pressure prior to administering the medication to ensure compliance by 8/5/2024.

The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the steps to follow when a medication is not in stock, as well as proper documentation that describes all the steps that were taken to ensure the resident receives their medications as ordered. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation.

The DON or Designee will also educate all nurses by 8/5/2024 on the importance of following orders in regard to blood

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F 760	Continued From page 234 Review of Resident #269's medical record revealed the admission assessment was completed by Nurse #9 on 3/7/24 at 3:22 PM. Review of Resident #269's March 2024 Medication Administration Record (MAR) revealed haloperidol 20 mg was scheduled to be administered at 8:00 PM. The MAR was blank on 3/7/24 for the scheduled 8:00 PM dose. The MAR revealed the medication was electronically signed as administered on 3/8/24, 3/9/24, 3/10/24, 3/11/24, 3/12/24, and 3/13/24. The MAR further revealed that Resident #269 did not receive carvedilol 12.5 mg twice daily from admission on 3/7/24 through the morning of 3/14/24 as indicated in the hospital discharge summary. This resulted in 14 missed doses of the medication from admission on 3/7/24 through the morning of 3/14/24. Resident #269's admission Minimum Data Set (MDS) dated 3/14/24 indicated resident was cognitively intact and received antipsychotic medication. Review of Resident #269's March 2024 MAR revealed vital signs were to be obtained every shift. On 3/14/24 day shift (7:00 AM to 3:00 PM) the following were recorded: Blood pressure 162/90 (elevated), pulse 113 (elevated), respirations 20 and temperature 97.0 degrees Fahrenheit. Review of Resident #269's electronic health record revealed a nursing progress note written by Nurse #9 dated 3/14/24 at 12:10 PM which indicated resident complained of shortness of breath and stated he did not feel right. Resident #269's vital signs were: blood pressure 136/90,	F 760	pressure parameters to ensure the resident receives or does not receive the medication related to the parameters set by the provider. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit medication administrations 5 times per week for 12 weeks to ensure all medications are given as ordered. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Beginning 7/27/2024, the DON or Designee will interview 3 residents per week x 12 weeks to ensure his/her pain is being managed effectively. Any missed administrations will result in re-education with the appropriate staff members and employee disciplinary action will be taken if necessary. Any pain that a resident expresses that is not being managed effectively will be reported to the provider. Beginning 7/27/2024, the LNHA or Designee will audit the nursing audits completed by the DON or Designee weekly x 12 weeks to ensure compliance for the facility. If it is identified that the nursing audits are not completed in compliance with the Plan of Correction (POC) it will result in re-education with the appropriate staff members and employee disciplinary action will be taken if	

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pulse 113 (elevated), respirations 22, temperature 97.5 and oxygen saturation of 98% on 3 liters of oxygen. Resident #269 requested to go to the hospital. On 3/14/24 at 12:25 PM Resident #269 went out of the facility to the emergency department.

An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:00 PM. Nurse # 9 stated she was no longer employed at the facility. Nurse #9 stated she was assigned to Resident #269 on 3/14/24 when he requested to be sent to the emergency room for evaluation. Nurse #9 stated Resident #269 was not doing well that day. Nurse #9 further stated Resident #269 complained of not feeling well, stating he knew something was wrong, his pulse was elevated, he was short of breath and reported he did not feel good all over. Nurse #9 stated after she sent Resident #269 to the hospital, she reviewed his medications and saw the dose of haloperidol was 20 mg. Nurse #9 stated she did not administer Resident #269 haloperidol on her shift as it was ordered to be given on night shift. Nurse #9 indicated if she saw a dose of 20 mg of haloperidol on the MAR to be given, she would not have given it since it was a higher dose than normally ordered. Nurse #9 stated she would clarify a dose that was higher than normal with the doctor.

An Emergency Department (ED) Provider Report dated 3/14/24 at 4:24 PM indicated Resident #269 was evaluated with a chief complaint of shortness of breath. Chest x ray and laboratory tests were obtained with no further treatment required. Vital signs upon discharge from the emergency department were blood pressure 138/88, respirations 18 and oxygen saturation 94 percent. The discharge medication list indicated

necessary.

Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.

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Resident #269 was to receive in part the medication haloperidol 2 tablets of 2 mg at bedtime and carvedilol 12.5 mg twice per day. There was no indication in the ED report of the significant medication errors with haloperidol or carvedilol.

Review of the electronic health record for Resident #269 revealed the resident returned to the facility on 3/14/24 at 6:44 PM.

Review of Resident #269's physician orders revealed an order dated 3/14/24 for haloperidol 2 mg give 1 tablet at bedtime for mood. The order was entered by the previous DON and was discontinued on 3/15/24.

Review of the March 2024 MAR for Resident #269 revealed haloperidol 2 mg give 1 tablet at bedtime on 3/14/24 at 8:00 PM was documented with a "9" indicating to see nurses notes. Review of Resident #269's nursing progress notes revealed there was no corresponding note on 3/14/24 at 8:00 PM.

Review of Resident #269's physician orders revealed an order dated 3/15/24 for haloperidol 2 mg give 2 tablets at bedtime for mood.

Review of Resident #269's electronic health record revealed an incident note written by Nurse #4 on 3/15/2024 at 3:58 PM. The note indicated Resident #269's order for haloperidol was transcribed in the computer incorrectly. The progress note indicated Resident #269 received the incorrect dose of haloperidol on 3/8, 3/9, 3/10, 3/11, 3/12, and 3/13/24.

Attempts were made to interview Nurse #4 via

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phone with messages left on 6/11/24 and 6/12/24 with no return call received. Nurse #4 no longer worked at the facility.

The order for carvedilol 12.5 mg indicated in the 3/14/24 ED discharge summary was not entered into Resident #269's physician orders when the resident returned to the facility.

The March 2024 MAR revealed that Resident #269 did not receive carvedilol 12.5 mg twice daily on the evening of 3/14/24 through the morning of 3/20/24 as indicated in the ED discharge summary. This resulted in 12 missed doses of the medication.

A nursing progress note dated 3/20/24 at 11:50 AM written by Nurse #7 stated resident was discharged home.

An interview was conducted with Nurse #13 via phone on 6/27/24 at 12:50 PM. Nurse #13 was assigned to Resident #269 on 3/8/24 from 7:00 PM to 7:00 AM and administered the haloperidol 20 mg on 3/8/24 at 9:00 PM. Nurse #13 stated she administered the medication as ordered and documented on the MAR. Nurse #13 did not recall any further information regarding the dose of haloperidol.

An interview was conducted via phone with Nurse #8 on 6/13/24 at 5:12 PM. Nurse #8 confirmed she was assigned to Resident #269 from 7:00 PM to 7:00 AM on 3/9/24 and she administered haloperidol 20 mg according to the physician order and as documented on the MAR. Nurse #8 stated she did not think about it at the time to clarify or hold the haloperidol due to an excessive dose.

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An interview was conducted with Unit Manager #1 on 6/13/24 at 9:30 AM. Unit Manager #1 stated she was assigned to Resident #269 on 3/11/24, 3/12/24 and 3/13/24. Unit Manager stated she administered the ordered doses of haloperidol to Resident #269 at 9:00 PM on 3/11/24, 3/12/24 and 3/13/24. Unit Manager #1 stated she did not question the dose or obtain a clarification of the dose prior to administering it.

An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated normally, the floor nurses entered the orders in the computer without verifying the orders with the Physician when a resident was admitted. Unit Manager #2 stated she was not sure who was supposed to fax the orders from the hospital, that she did not do it and she thought it must be someone from administration. Unit Manager #2 confirmed she was assigned to Resident #269 on 3/10/24 and her electronic signature on the MAR indicated she administered the 9:00 PM dose of haloperidol 20 mg. Unit Manager #2 stated it did not occur to her to clarify the dose or hold the haloperidol due to the dose of 20 mg ordered being higher than a usual dose ordered.

An interview was conducted via phone with the previous Director of Nursing (DON) on 6/13/24 at 1:20 PM. The previous DON stated she entered the orders into the computer for Resident #269 on 3/7/24 when he was admitted to the facility from the hospital. She stated she entered the order for haloperidol incorrectly. She indicated she did not know why she put the order in incorrectly and couldn't say what happened. The previous DON revealed she was not aware she

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omitted the order for carvedilol and she did not have an explanation for why other than human error. The previous DON indicated she did not recall if she sent the discharge summary to the pharmacy. The previous DON stated she recalled Resident #269 went to the emergency room but did not know why or the outcome. The previous DON stated she left the position at the facility shortly after the resident was sent to the hospital.

An interview was conducted via phone with the Pharmacy Quality Assurance Specialist on 6/12/24 at 11:50 AM. The Quality Assurance Specialist indicated the pharmacy dispensed 30 tablets of haloperidol 20 mg on 3/7/24 for Resident #269. The Quality Assurance Specialist indicated the pharmacy did not receive the hospital discharge summary dated 3/7/24 for Resident #269. The Quality Assurance Specialist stated normally the pharmacist compared the discharge summary and the orders that were entered and would call the facility for clarification or to report discrepancies. The Quality Assurance Specialist indicated documentation in the pharmacy record indicated the pharmacy did not receive a discharge summary for Resident #269. The pharmacy record indicated the pharmacist called the facility on 3/7/24 and was informed by the previous Director of Nursing (DON) to send all Resident # 269's medications as they were entered into the computer. Precautions indicated to use haloperidol with extreme caution with residents with cardiac arrhythmia. The Quality Assurance Specialist stated there was no dosage warning in the computer for the haloperidol dosage.

An interview was conducted via phone with the

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Consultant Pharmacist on 6/12/24 at 9:15 AM. The Consultant Pharmacist indicated haloperidol 20 mg was a high dose which was usually only prescribed in an acute setting with a major psychiatric diagnosis. The Consultant Pharmacist indicated the high dose of haloperidol had the potential for adverse effects including harm and receiving the medication at that dose for a sustained period increased the likelihood of effects. The Consultant Pharmacist stated adverse effects could include but were not limited to sedation, somnolence, movement disorders, drooling and severe respiratory difficulty. The Consultant Pharmacist stated the haloperidol error was a significant medication error. The Consultant Pharmacist reported the omission of carvedilol could result in harm due to potential for exacerbation of atrial fibrillation (irregular heart rate) and congestive heart failure. The Consultant Pharmacist indicated there was a systemic problem with medication administration in the facility for some time and she addressed this with the current DON when she started in March. The Consultant Pharmacist indicated the pharmacy was supposed to receive a copy of the discharge orders to reconcile that with what was entered into the computer by the facility.

An interview was conducted via phone with the Physician on 6/11/24 at 1:00 PM. The Physician stated she was new to the facility having started on 6/7/24. The Physician stated in her career as a physician she had never prescribed a dose of 20 milligrams of haloperidol. The Physician indicated the recommended dose that she would prescribe was 2.5 milligrams to 5 milligrams as a one-time dose for an acute psychotic episode. The Physician further stated 6 doses of 20 mg of haloperidol had the potential for serious adverse

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effects such as sedation, increased tiredness, and respiratory difficulty. The Physician reported the omission of carvedilol from Resident #269's medication list from admission on 3/7/24 through discharge on 3/20/24 was concerning and had the potential for serious adverse effects including changes in blood pressure, heart rate, shortness of breath and worsening of congestive heart failure.

An interview was conducted with the current Director of Nursing (DON) on 6/12/24 at 2:15 PM. The DON indicated the incorrect dose of haloperidol administered to Resident #269 was a significant medication error. The DON stated she was aware of the error with the transcription of Resident #269's orders and stated the error was made by the previous DON. The DON stated she did not recall how she was made aware of the error. The DON stated she expected orders to be transcribed correctly and the discharge summary to be faxed to the pharmacy by the floor nurse.

An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated it was her expectation that medications would be transcribed and administered correctly. She stated she was unaware of the error that occurred with the transcription of Resident #269's medications.

2. Resident #51 was admitted on 10/19/23 with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities).

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Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain.

Review of Resident #51's quarterly Minimum Data Set (MDS) dated 4/4/24 indicated resident was cognitively intact and exhibited no behaviors. The MDS assessment was coded as received scheduled and as needed pain medication. The pain interview was not assessed.

The May 2024 Medication Administration Record (MAR) indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:

5/8/24
- The MAR for 5:00 PM indicated Nurse #8 documented a "9" and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy.
- The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note.

5/9/24
- The MAR for 9:00 AM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.
- The MAR for 12:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.
- The MAR for 5:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.

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- The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note.

Following readmission to the facility on 5/8/24, a pain assessment dated 5/9/24 was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain.

A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain.

An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/10/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 stated "9" documented on the MAR indicated the medication was not available. If a medication was not available, she stated she would wait a few days and then notify Unit Manager #1. Nurse #8 stated she did not recall when, but she knew she notified Unit Manager #1 that Resident #51's gabapentin was not available. Nurse #8 stated Resident # 51 was frustrated about not receiving the medication gabapentin as ordered.

A nursing progress note written by Nurse #8 on 5/10/24 at 3:24 AM indicated Resident #51 reported her legs were numb. The note indicated the nurse informed there were no interventions for this and offered emergency room evaluation. Resident #51 declined to be sent to the

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emergency room.

The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/10/24
- The MAR for 9:00 AM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.
- The MAR for 12:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.
- The MAR for 5:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse #13 documented a "9" and the corresponding administration record note at 10:12 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.

An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse # 9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse # 9 stated Resident # 51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse # 9 revealed she documented "9" which indicated the medication was not available for the doses. Nurse # 9 stated she did not attempt to obtain medication for Resident #51.

An interview was conducted via phone with Nurse #13 on 6/27/24 at 12:50 PM. Nurse #13 stated Resident #51's gabapentin was unavailable, and she had not administered it. Nurse #13 stated she did not attempt to obtain the medication for Resident #51.

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The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/11/24
- The MAR for 9:00 AM indicated Unit Manager #1 documented a "9" and there was no corresponding nursing note.
- The MAR for 12:00 PM indicated Unit Manager #1 documented a "9" and there was no corresponding nursing note.
- The MAR for 5:00 PM indicated Nurse #14 documented a "9" and the corresponding progress note on 5/11/24 at 4:15 PM indicated gabapentin 800 mg was pending from the pharmacy and the nurse pass on information to next shift to follow up.
- The MAR for 9:00 PM indicated Nurse #2 documented a "9" and there was no corresponding nursing note.

An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not recall if she made any attempt to obtain the medication for Resident #51.

Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received.

A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to

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emergency room. Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal from not receiving her medication as ordered.

An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated for a chief complaint that the facility had been out of her gabapentin for a couple of days and now she was experiencing full body cramps. The ED Summary stated Resident #51 presented to the ED on 5/12/24 at 4:22 AM and reported she had not had her gabapentin and thought she was in gabapentin withdrawal. While in the ED, at 4:43 AM on 5/12/24 Resident #51 was administered gabapentin 800 mg. The discharge instructions were to restart gabapentin 800 mg 4 times per day, to follow up with her primary care physician and to not stop taking prescription medication for pain suddenly. Resident #51 was discharged back to the facility on 5/12/24 at 6:11 AM.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM. Nurse #2 was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider and sent Resident #51 to the hospital.

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A progress note written by Nurse #14 on 5/12/24 at 10:09 AM indicated Resident #51 returned from the hospital at approximately 8:00 AM. Unit Manager #1 was made aware on 5/11/24 that Resident #51 had not received her gabapentin and was sent to the emergency room last night to obtain it.

The MAR for 5/12/24 revealed Nurse #14 inaccurately documented a "6" for the 9:00 AM, 12:00 PM, and 5:00 PM doses of Resident #51's gabapentin which indicated the resident was in the hospital. (Resident #51 returned from the ED on 5/12/24 at approximately 8:00 AM [per Nurse #14's progress note] and the next scheduled dose of gabapentin was due at 9:00 AM).

Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received.

A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening "muscle spasms all over" and requested to go to the emergency department. 911 was called for transfer to the emergency room. Resident #51 returned to the facility having received gabapentin at the emergency room. Resident #51 told the emergency room staff that until she received her gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. Emergency room physician sent a new prescription for gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM.

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An ED Summary dated 5/12/24 at 8:50 PM indicated Resident #51 presented with muscle spasms and reported she was unable to get her gabapentin prescription refilled at the nursing facility and was having breakthrough pain. The Medication Administration Record for the ED indicated Resident #51 was administered gabapentin 800 mg on 5/12/24 at 9:12 PM. Resident #51 was discharged back to the facility on 5/12/24 at 9:41 PM with instructions to continue with gabapentin 800 mg 4 times per day.

The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:
5/13/24
- The MAR for 9:00 AM indicated Nurse #15 documented a "9" and the corresponding administration record note at 10:05 AM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.
- The MAR for 12:00 PM indicated Nurse #15 documented a "9" and the corresponding administration record note at 1:41 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy.
- The MAR for 5:00 PM indicated Nurse # 15 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse # 11 documented a "9" and the corresponding administration record note at 10:52 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy

Pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on 5/13/24.

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A 6/7/24 nursing progress note indicated Resident #51 was transferred to the hospital due to a change in condition. Resident #51 remained in the hospital as of 6/19/24 and was unavailable for interview.

An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks. Unit Manager #1 recalled Resident #51 ran out of gabapentin and required emergency room evaluations due to not receiving the medication. Unit Manager #1 did not recall when or how she became aware of the medication errors of Resident #51 not receiving the ordered medication gabapentin.

An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist stated she discussed the problems with obtaining medications for administration in March when the current Director of Nursing (DON) came into the position at the facility. The Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate) and was a significant medication error. The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe.

An interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated Resident #51 not receiving the prescribed medication gabapentin from 5/8/24 through 5/13/24 was a significant medication error. The DON revealed the Consultant Pharmacist had informed her of the problem with gabapentin not

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being available but being new to the DON position, she had not investigated the problem. The DON stated a system was required in the facility to track medication refills to prevent further significant medication errors due to not obtaining refills.

An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications would be administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identified that a medication was not available for administration.

An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. The Physician indicated omission of an ordered medication was a medication error and had the potential for serious adverse outcome. The Physician revealed Resident #51 being sent to the hospital for evaluation due to increased pain was the outcome of not receiving the scheduled doses of the medication gabapentin as ordered by the physician. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered.

3. Resident #46 was admitted on 12/6/23 with diagnosis which included diabetes and

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neuropathy.

Review of Resident #46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain.

Resident #46's quarterly Minimum Data Set (MDS) assessment dated 3/12/24 indicated resident was cognitively intact with no behaviors. Resident #46 received scheduled and as needed pain medication, pain interview should be conducted, and resident had no pain in the previous 5 days.

Review of a Controlled Drug Record for Resident #46 revealed the last dose from the supply of gabapentin delivered on 4/8/24 was signed out by Nurse #7 on 5/10/24 at 8:00 AM bringing the count to 0 pills remaining.

The May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM and specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #46's pain medication:

5/10/24
- The MAR for 9:00 PM indicated Nurse # 3 documented a "9" and there was no corresponding nursing note.

5/11/24
- The MAR for 9:00 AM indicated Nurse #6 documented as the medication was administered.
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note.

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5/12/24
- The MAR for 9:00 AM indicated Nurse #6 documented a "9". The corresponding nursing note at 9:09 AM indicated awaiting pharmacy delivery of gabapentin.
- The MAR for 9:00 PM indicated Nurse #3 documented a "9" and there was no corresponding nursing note. A pain level of 9 was recorded at 9:37 PM.

5/13/24
- The MAR for 9:00 AM indicated Nurse #6 documented a "9". The corresponding nursing note at 9:44 AM indicated awaiting pharmacy delivery of gabapentin.
- The MAR for 9:00 PM indicated Nurse #17 documented a "9". A pain level of 8 was recorded at 10:50 PM. The corresponding nursing note at 10:53 PM indicated the medication on order from pharmacy.

5/14/24
- The MAR for 9:00 AM indicated Nurse #7 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse #17 documented a "9" and there was no corresponding nursing note.

5/15/24
- The MAR for 9:00 AM indicated Nurse #7 documented a "9" and there was no corresponding nursing note.
- The MAR for 9:00 PM indicated Nurse #17 documented a "9" and there was no corresponding nursing note.

5/16/24
- The MAR for 9:00 AM indicated Unit Manager #2 documented a "9". The corresponding nursing note at 9:17 AM indicated waiting for delivery of gabapentin from pharmacy.
- The MAR for 9:00 PM indicated Nurse # 11

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documented a "9". The corresponding nursing note on 5/17/24 at 12:40 AM indicated awaiting medication delivery from pharmacy.
5/17/24
- The MAR for 9:00 AM indicated Nurse #5 documented a "9". An administration note dated 5/17/24 at 10:09 AM indicated awaiting medication delivery of gabapentin from pharmacy.
- The MAR for 9:00 PM indicated Nurse #2 documented a "9" and there was no corresponding nursing note. A pain level of 7 was recorded at 9:04 PM.

An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented 9 on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin and indicated the medication was not administered due to it being unavailable. Nurse #3 stated Resident #46 had pain and was unable to sleep when she did not receive the medication gabapentin.

An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that worked at the facility for several months. Nurse #6 stated gabapentin was not available on the medication cart for Resident #46 for the scheduled 9:00 AM, 12:00 PM and 5:00 PM doses on 5/12/24 and 5/13/24. Nurse #6 stated she did not administer the scheduled doses of gabapentin.

An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about

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6 weeks. Nurse # 17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated gabapentin was not available on the medication cart for the ordered doses at 9:00 PM. Nurse #17 stated she did not notify the pharmacy or the provider that the medication was not available. Nurse #17 revealed gabapentin was prescribed for pain and Resident #46 exhibited increased pain, irritability and anxiety from not receiving the medication.

An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident # 46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 stated Resident # 46 was upset and had increased pain when she did not receive the ordered gabapentin.

An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered and she did nothing about Resident # 46's medication not being available.

An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM, did not call the pharmacy to obtain

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the medication and observed Resident #46 in pain. Nurse #5 stated she the medication was on order, so she did not attempt to obtain it.

An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated she did not administer the ordered gabapentin at 9:00 PM on 5/17/24 due to it being unavailable.

Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM. Messages were left on 6/11/24 and 6/12/24 with no return call received.

An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated the facility had trouble obtaining medications. Resident #46 stated she had gone without medications for days at a time on several occasions. Resident #46 reported staff stated the medication was coming from the pharmacy but then it didn't come in. Resident #46 indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not receive her ordered gabapentin. Resident #46 stated it was horrible and the staff told her she would just have to wait it out until the medication came in.

Review of a 5/27/24 Medication Record Review by the Consultant Pharmacist indicated a medication error was identified in Resident #46's electronic health record. The note indicated

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gabapentin was marked out of stock for 13 doses in May 2024. The Pharmacist indicated to review this with staff.

An interview was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. In March when the current Director of Nursing (DON) started, the Consultant Pharmacist stated she held a meeting with the DON to discuss her concern with significant medication errors due to the omission of ordered medications. The Consultant Pharmacist indicated the omission of gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate) and was a significant medication error.

An interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for Resident #46 and the omission of a prescribed medication was a significant medication error. The DON stated she met with the Consultant Pharmacist when she started in March and discussed medication errors due to the omission of medications. The DON stated she thought there was a problem with the fax machines in the facility and that the pharmacy was not receiving orders and refill requests. The DON stated the pharmacy provided new fax machines but there continued to be problems and she did not know why.

A follow up interview with the DON on 6/12/24 at 4:15 PM revealed the nurses on the medication cart were expected to reorder medications within 5-7 days of the supply being depleted so that ordered medications were not omitted due to being unavailable. The DON stated she was

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aware Resident #46 did not receive ordered gabapentin 800 mg twice per day from 5/10/24 through 5/17/24, that this was a significant medication error and she had not investigated this.

An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications to be administered as ordered by the physician and the omission of a medication was a medication error. The Administrator stated nursing staff did not understand what to do when a medication was not available for administration.

An interview was conducted via phone with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg twice per day, was a high dose of medication and it was not recommended to abruptly stop taking the medication. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered. The Physician indicated the omission of the ordered medication gabapentin for Resident #46 was a significant medication error and had the potential for adverse outcome. The Physician stated it was the facility's responsibility to obtain the medications and administer them as ordered.

4. Resident #419 was admitted to the facility most recently on 08/07/23.

Diagnoses included, in part, a sacral stage 4 pressure ulcer, Type 2 Diabetes Mellitus, hemiplegia and hemiparesis following a stroke (cerebral infarction) affecting his dominant right side, congestive heart failure, and altered mental status.

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Review of a quarterly MDS assessment date 02/09/24 revealed Resident #419 had severely impaired cognition. Both upper and lower extremities on one side were impaired. He had one stage 4 pressure ulcer and one deep tissue injury that were not present on admission. He had received pressure ulcer care.

On an Outpatient Treatment Order Set document from the community Wound Care Center the Wound Care physician ordered the following intravenous (IV) antibiotic medications on 02/23/24 for Resident #419: 1) Rocephin 2 grams intravenous daily x 4 weeks, 2) Daptomycin 500 Milligrams (mg) intravenous daily x 4 weeks, 3) PICC line insertion (a type of long catheter that is inserted through a peripheral vein, often in the arm, into a larger vein in the body, used when IV treatment is required over a long period), and 4) first dose at the hospital then additional doses at Premier Living nursing home.

Nurse #8 documented in a progress note dated 02/23/24 at 2:15 AM that Resident #419 returned to the facility from the hospital. He had been sent to the hospital to have a PICC line placed and receive his first round of antibiotic therapy. Nurse #8 documented the PICC line nurse at the hospital called and stated she was unable to place the PICC line and a (peripheral) IV had been placed in his left forearm for medication administration. The first infusion of Daptomycin 500 mg and Rocephin 2 grams was administered at the hospital.

The March 2024 Medication Administration Records (MAR's) revealed the following orders: 1) Rocephin (Ceftriaxone) 2 grams intravenously

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one time a day for infection until 03/24/24, start date 2/25/24; and 2) Daptomycin intravenous solution reconstituted 500 mg intravenously one time a day for treatment of infection for 4 weeks, start date 02/25/24 and stop date 03/24/24. Documentation revealed the resident did not receive the antibiotic Rocephin on the following dates: 03/16/24, 03/17/24, 03/20/24, 03/21/24, 03/22/24, and 03/23/24; and he did not receive the antibiotic Daptomycin on these dates: 03/15/24, 03/16/24, 03/17/24, 03/20/24 03/21/24, 03/22/24, and 03/23/24.

A progress note written by Agency Nurse #2 on 3/15/24 at 3:38 pm documented Resident #419's IV had infiltrated (came out of the vein and leaked fluid into the surrounding tissue) and she was not able to give the 1:00 pm dose of antibiotic Daptomycin 500 mg. She made two unsuccessful attempts to restart the IV.

A progress note written by Nurse #13 on 03/16/24 at 12:28 am documented she attempted one time to place an IV in Resident #419's left forearm and was unsuccessful.

Progress notes written by Medication Aide #5 on 03/16/24 at 11:24 am and 12:14 pm documented Resident #419 did not receive his antibiotic medications because he did not have an IV.

A progress note written by Agency Nurse #2 on 03/17/24 at 4:36 pm documented an IV site was acquired and the antibiotics restarted.

On 3/17/24 the MAR was marked "9" (a code meaning other/see progress notes) by Medication Technician #1 for both the Rocephin 8:00 am dose and the Daptomycin 1:00 pm dose. The

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antibiotics were not documented on the MAR with a check mark that would have indicated the medications had been administered.

A progress note written by Agency Nurse #3 on 03/20/24 at 6:49 pm documented Resident #419's IV had not been working since the beginning of the shift. She attempted to restart the IV 3 times and the charge nurse tried to restart the IV 2 times, but all 5 attempts were unsuccessful. The scheduled antibiotics were not administered. She could not remember who the charge nurse had been but thought she was from an agency.

On 03/21/24 the MAR was marked "9" (a code meaning other/see progress notes) by Medication Aide #5 for both the Rocephin 8:00 am dose on and the Daptomycin 1:00 pm dose. The antibiotics were not documented on the MAR with a check mark that would have indicated the medications had been administered.

A progress note written by Agency Nurse #2 on 03/22/24 at 3:51 pm documented she had tried to start an IV for Resident #419, but the attempt was unsuccessful.

A progress note written by Nurse #13 on 03/23/24 documented Resident #419 did not receive his antibiotics because he had no IV access.

A nurse progress note written on 04/05/14 at 12:45 PM documented Resident #419 was sent to the hospital due to possible aspiration.

In an interview conducted on 06/12/24 at 9:50 AM with the facility consultant pharmacist she stated the consecutive missed doses of both antibiotics

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decreased the effectiveness of the medications and put the resident at risk for worsening of his infection. She stated the provider should have been notified or the resident should have been sent out to the hospital to get IV access established to enable the facility to administer the medications. She stated there should have been an intervention so that the resident could have been given the antibiotic medications.

In an interview with the Wound Care Nurse on 06/12/14 at 12:30 PM she stated the Nurse Practitioner (NP) was aware the IV was out. She noted the NP was supposed to come to the facility and restart the IV. She stated although she did not make a nursing note, she was positive the NP was aware Resident #419 had no IV access. She cared for Resident #419 on 03/23/34.

In an interview with the Agency Director of Nursing (DON) on 06/12/24 at 1:05 PM she stated she became employed at the facility on 03/25/24. She commented if she had been employed when the facility nurses could not establish IV access, she would have first tried to start the IV herself and if unsuccessful she would have called the provider, obtained an order for a PICC line and would have sent the resident out to have IV access established within 24 hours of the first unsuccessful attempt to re-establish IV access.

In an interview with Agency Nurse #2 on 6/12/24 at 1:50 PM she stated she was not sure why the resident was getting antibiotics and was not sure if she had tried to restart his IV access or not. She could not remember if she had notified the provider that the medications could not be

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administered. She cared for Resident #419 on 03/15/24 and 03/22/24.

In an interview with Nurse #3 on 6/12/24 at 1:55 PM she stated while she was working the IV site stopped working and she tried to restart the IV but could not. She commented that Resident #419 was a "hard stick" (meaning it was difficult to start his IV). Another agency nurse on duty tried and could not get the IV started. She passed on in report to the next nurse the unsuccessful attempts to restart the IV. She did not notify the provider that the resident had no IV access. She noted the nursing supervisor on duty also tried to start the IV and could not. She did not know the names of the other two nurses but thought they were also from an agency. She cared for Resident #419 on 03/19/24 and 03/20/24.

In an interview with Unit Manager #2 on 6/13/24 at 8:13 AM she stated she had notified the NP that the resident had no IV access but did not document a progress note. She could not remember the date she notified the NP.

In an interview with Nurse #20 on 07/01/24 at 10:10 am she stated she had cared for Resident #419 on 03/16/24, 03/19/24, and 03/21/24. She recalled when she assessed him to start an IV site, she could not find a vein. She did not understand why he came back from the hospital without a PICC line or a port that would support long term antibiotic treatment. She stated on the days she cared for Resident #419 she never administered his antibiotic medications because he did not have IV access. She recalled the NP was aware the resident did not have IV access.

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Multiple unsuccessful attempts were made to contact the NP on 06/12/14 at 1:48 PM and 3:36 PM. She had been employed at the facility in March 2024. An additional attempt was made on 06/13/24 at 3:07 PM with no response. Other attempts were made to contact the NP by different surveyors on the team throughout the survey week with no response.

Multiple unsuccessful attempts were made on 06/12/14 at 1:50 PM and 3:33 PM to contact the physician employed at the facility in March 2024. An additional attempt was made on 06/13/24 at 3:00 PM with no response. Other attempts were made to contact the physician by different surveyors on the team throughout the survey week with no response.

Review of the Wound Clinic assessment dated 03/22/23 of Resident #419's Stage 4 sacral ulcer revealed the wound measured 6.4 cm (Centimeters) long x 3.8 cm wide x 0.8 cm deep. The wound progress was deteriorating with a large amount of sero-sanguineous (a thin watery liquid mixed with blood) drainage. The wound was debrided with a minimal amount of bleeding. There was no odor. After debridement the wound measured 6.6 cm long x 3.9 cm wide x 0.9 cm deep. The skin surrounding the wound was moist, warm and reddened but did not exhibit signs of infection.

In an interview with the Wound Clinic physician on 6/14/24 at 12:23 PM he stated he was not notified that the resident did not have IV access. He explained he had ordered a PICC line to be placed at the hospital on 02/23/24 and for Resident #419 to receive his first dose of antibiotics there. He stated the resident had

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reached a plateau in treatment and the wound had increased drainage. He explained he often ordered antibiotics related to resident bacteria biofilm on a wound that had stalled. He stated the resident had a poor prognosis overall with limited longevity because he had so many comorbidities. He commented that the resident was very ill, and he doubted the missed doses of antibiotics would have affected the overall length of his longevity.

A progress note written by Agency Nurse #2 on 04/05/24 at 12:45 pm documented that Resident #419 had been sent to the hospital due to possible aspiration. She had notified the Wound Clinic that he had been sent out.

Review of the hospital discharge summary dated 04/26/24 revealed Resident #419 was diagnosed with: 1. altered mental status, 2. sepsis due to aspiration pneumonia, 3. suspected congestive heart failure, 4. dysphagia (trouble swallowing), 5. electrolyte abnormalities, 6. stage 4 pressure ulcer of the sacra region, 7. toxic metabolic encephalopathy/acute delirium, 8. right staghorn nephrolithiasis and distal ureterolithiasis, 9. hypertension, 10. seizure disorder, 11. Type 2 Diabetes Mellitus, and 12. vascular dementia. The hospital physician documented that "the patient remained obtunded during the remainder of his hospital stay and the suspicion was that the patient likely had an underlying infection as he was noted to have a low grade temperature and resting tachycardia. The presumption was that the patient's sepsis likely centered around his large Stage 4 decubitus (pressure ulcer) as he likely has chronic sacral osteomyelitis." The resident was discharged from the hospital to a Hospice Care facility with comfort measures only.

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The Administrator was notified of Immediate Jeopardy on 6/12/24 at 5:34 PM.

The facility provided the following IJ Removal Plan:

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

The facility failed to prevent significant medication errors (Resident #269, Resident #419, Resident #51, and Resident #46).

The facility failed to correctly transcribe hospital discharge orders when resident was readmitted to the facility on 03/14/2024 (Resident #269). Resident #269 was first admitted to the facility on 03/07/2024. On 03/14/2024 Resident #269 had a chief complaint of shortness of breath and requested to go to the Emergency Room (ER). Resident #269 did have a documented change of condition where the resident was sent to the ER. Resident #269 returned to the facility with hospital discharge orders which were transcribed incorrectly. Resident #269 was sent back to the facility with orders for haloperidol 2 mg 2 tablets at bedtime and carvedilol 12.5 mg twice daily. It was determined that the facility failed to administrator the correct dosage of haloperidol from 03/07/2024 through 03/13/2024. Resident #269 received 6 doses of haloperidol 20mg due to a transcription error on admission. The facility failed to transcribe the carvedilol 12.5 mg upon admission on 03/07/2024 and readmission on 03/14/2024. The facility failed to administer 26 doses of carvedilol 12.5 mg as ordered due to the failure of transcription. Resident #269 continued to not receive this medication through discharge

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from the facility on 03/20/2024.

The facility failed to administer a routine order of gabapentin 800 mg 4 times a day between the dates of 05/08/2024 to 05/13/2024 (Resident #51). Resident #51 complained of pain. On 05/09/2024 Resident #51 refused a shower due to too much pain. On 05/10/2024 Resident #51 complained of legs feeling numb. On 05/12/2024 Resident #51 complained of pain and spasming in which Resident #51 requested to go to the ER. Resident #51 returned from the ER where the resident was treated for acute pain and received gabapentin at the hospital. In the evening on 05/12/2024 Resident #51 complained of agitation and anxiety due to not receiving gabapentin and requested to go to the ER. Resident #51 received gabapentin in the ER. The facility failed to administer a total of 21 doses of gabapentin between 05/08/2024 and 05/13/2024 to Resident #51.

The facility further failed to administer a routine order of gabapentin (Resident #46). Resident #46 had a routine order for gabapentin 800 mg 2 times a day. Resident #46 complained of not receiving this medication which caused more pain and made it hard to sleep. Resident #46 complained of irritability, being anxious, and nausea. Resident #46 had not felt well and had not been able to get out of bed to participate in activities and perform a daily routine due to pain in her legs. Resident #46 missed 14 doses of gabapentin between 05/10/2024 and 05/17/2024. Resident #46 had a pain level of 8 or 9 constantly during the time the facility failed to administer the gabapentin.

The facility failed to administer the antibiotic

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Ceftriaxone 2 mg intravenous (IV) for 6 days and the antibiotic Daptomycin 500 mg intravenous (IV) for 7 days between the days of 03/15/2024 through 03/23/2024 (Resident #419). It was determined that the antibiotics were ordered for an infected Stage 4 sacral wound. However, Resident #419 did not ever receive the IV antibiotics as ordered and experienced low grade temperatures and resting tachycardia.

On 06/12/2024 the Director of Nursing identified that all residents have the potential to experience adverse and/or serious outcomes as a result of the deficient practice. The Director of Nursing also identified that all residents who are admitted and readmitted to the facility are at high risk as a result of transcription errors and missed medication orders. Additionally, the Director of Nursing identified that all residents with stageable and unstageable wounds requiring antibiotic therapy and peripheral or intravenous lines are at high risk for missed medication administration.

On 06/13/2024 Unit Managers (UM) completed an audit for the past 90 days of all admissions and readmissions to determine what medication orders the resident was admitted with and if the orders were transcribed correctly into the electronic medical records system. The audit showed that out of 53 admissions and readmissions there were 5 identified transcription errors. The 5 identified transcription errors were corrected post audit on 06/13/2024. The physician was made aware of the identified transcription errors and informed of the corrections.

On 06/13/2024 the Administrator and Director of Nursing consulted with the facility Consultant

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Pharmacist to further investigate the gabapentin administration errors that occurred 05/08/2024 - to 05/17/2024. It was determined that the pharmacy had made an error and not shipped the medication in a timely manner. It was further determined that nursing staff do not have a comprehensive understanding of what to do when they identify that a medication is not available for administration.

On 06/13/2024 the UMs also completed an audit for the past 90 days of all residents to determine if any residents were ordered IV medications and if so if the IV medications were administered. It was determined by the Director of Nursing through this audit that either the IV medications for residents were not readily available when prescribed and/or ordering through an ordering deficit practice by not ordering IV medication in a timely manner. Therefore, resulting in a facility deficient practice of administering IV medications. The new primary care provider for the facility who started on 06/07/2024 was made aware of the identified IV medication administration errors on 06/14/2024 upon completion of the audit.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete:

On 04/01/2024, the Director of Nursing introduced the process of triple admission check to UMs. The Director of Nursing identified that the UMs did not have a comprehensive understanding of the triple admission check which is why there were transcription errors after 04/01/2024. On 06/12/2024, the Director of Nursing reintroduced the process of triple

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admission check to UMs and newly introduced the triple admission check to all Nurses. As of 06/12/2024 the process is as follows; Upon resident admission to the facility the Director of Nursing will assign a Floor Nurse to the admission. The assigned Floor Nurse will review the hospital discharge orders for the given resident. The assigned Floor Nurse will then highlight the discharge orders that need to be continued and/or changed. The assigned Floor Nurse will then enter this information under the order tab in the electronic medical records system after the resident has been admitted to the facility and is physically in the facility.

Within the first 24 hours of the resident's admission to the facility, the Director of Nursing will initiate a second admission check to be performed on the resident. This process includes reviewing diagnoses, admitting orders, medications, diet, labs, etc. The second admission check is performed by 2 Nurses who the Director of Nursing assigns to complete the task. The Director of Nursing will ensure that one of the 2 Nurses assigned to complete the second admission check is not the original Floor Nurse who put in the orders. The next step for the Floor Nurse is to create a checklist of any missed orders, questionable orders, and/or items not completed or found within the initial admission check. The checklist is to be completed by no later than 5:00pm on this day and given to the Director of Nursing who will keep record of the checklist each day. The Director of Nursing will then follow up on the checklist the next morning to ensure all actions have been completed correctly.

On 06/12/2023 the Director of Nursing educated

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nurses on the triple admission check to ensure they understand the new process that has been implemented to prevent future transcription errors. This education is to include all nurses who are full-time, part-time, as needed, and agency staff.

On 06/12/2024 the Director of Nursing ensured that a daily medication refill log will be maintained by the UMs to ensure that medications are obtained from the pharmacy in a timely manner to prevent further medication administration delays. The Director of Nursing educated UMs on the daily medication refill process to ensure their comprehension and knowledge.

Effective 06/12/2024 the Director of Nursing will educate newly hired nurses on the triple admission check process and the daily medication refill log to ensure the facility is following orders for order transcription and medication administration. This education is to include all newly hired nurses who are full-time, part-time, as needed, and agency staff. No nurse will work on the floor after 06/12/2024 until the nurse has been educated on the triple admission check process and the daily medication refill log process. Nurses will receive this education from the Director of Nursing to avoid serious harm or impairment to current and future residents at the facility.

As of 06/12/2024 the Director of Nursing will educate all nurses regarding the allowable time lapse for a medication being ordered. The education will include receiving medication in the facility and how to utilize the emergency medication system. If a medication is not in the system, the nurse must contact the on-call

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primacy care provider. This education is to include all nurses who are full-time, part-time, as needed, and agency staff.

Effective 06/14/2024 the Director of Nursing will educate all nurses who are full-time, part-time, as needed, and agency staff on following physician orders to ensure accurate transcription and administration of IV medications. If there are barriers with IV medication administration nurses will notify the Director of Nursing immediately.

Effective 06/14/2024 the Director of Nursing will ensure that no nurse will work in the facility until the nurse has received education and has a comprehensive understanding of following physician orders to ensure accurate transcription and administration of IV medications.

As of 06/12/2024, the Director of Nursing will be responsible for tracking the nursing education and ensuring it is completed so that the facility has an effective system in place to ensure orders are transcribed correctly and that residents are administered their ordered medications.

Alleged immediate jeopardy removal date: 6/15/24

The removal plan of the Immediate Jeopardy was validated on 06/19/24. A sample of staff including the Administrator, Unit Manager, Nurses, and Medication Aides were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding the triple check process to ensure new orders were transcribed accurately, the allowable time lapse for a medication being ordered and how to utilize the

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emergency medications system and following physician orders to ensure administration of IV medications. Nursing staff explained that the assigned floor nurse would clarify the orders from the discharge summary from the hospital, enter the orders in the electronic medical record. Within 24 hours, the second check was to be done to include reviewing diagnoses, medications, diet, labs, etc. by 2 nurses ensuring 1 of the 2 nurses was not the original nurse who put the orders in. The nursing staff explained that once all the orders were in and checked and sent to the pharmacist, they were to create a checklist of any missed orders within 24 hours and give to the Director of Nursing to follow up on. Observation of nursing staff was conducted to ensure they understood how to enter orders in the electronic record and receive confirmation that the refilled order was processed. Additionally, the nursing staff explained the process of utilizing the refill log. Nursing staff were to utilize the medication refill form to ensure medications were being delivered from the pharmacy once ordered. Staff stated if a medication was not delivered from the pharmacy as ordered, the Unit Manager would follow up with the pharmacy the next day. The Unit Manager confirmed understanding of this implemented process. An audit was completed on 06/13/2024 by the Unit Managers for the past 90 days of all admissions and readmissions to determine what medication orders the resident was admitted with and if the orders were transcribed correctly into the electronic medical records system. The audit showed that out of 53 admissions and readmissions there were 5 identified transcription errors. The 5 identified transcription errors were corrected post audit on 06/13/2024. The physician was made aware of the identified

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transcription errors and informed of the corrections. The Unit Managers also completed an audit for the past 90 days of all residents to determine if any residents were ordered IV medications and if the IV medications were administered. Audits for the IV administration orders were reviewed with concerns identified and corrected. The physician was made aware of the identified errors and informed of the corrections. The removal date of 06/15/24 was validated.

5. The hospital discharge summary dated 04/26/24 documented the following physician order: Amoxicillin-Clavulanate 875 mg-125 mg oral tablet one tablet oral every 12 hours for 7 days, (Augmentin).

Resident #39 was admitted to the facility on 05/02/24 with a diagnosis of a urinary tract infection (UTI).

Review of the order audit details revealed Nurse #7 had entered the admission orders from the hospital discharge summary into the computer system on 05/02/24 at 4:31 PM for Resident #39.

In an interview with Agency Nurse #7 on 06/14/24 at 8:30 AM she stated she did not remember entering the admission orders for Resident #39. She noted she worked for an agency and that this was the only facility that did not review admission orders with the provider for approval prior to entering them into the computer system. It was her understanding that someone else faxed the discharge summary to the pharmacy before she was given the discharge orders to enter into the computer. She said she did not remember putting the orders in because

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she had to manage the hall she was working on, pass medications and cover medication aides who might be on a cart. In addition to all that, she explained the floor nurses also had to enter 3 to 4 admission sets of orders a shift into the computer.

An admission Minimum Data Set (MDS) assessment dated 05/08/24 revealed Resident #39 had intact cognition. He had an indwelling urinary catheter. He had undergone recent genitourinary surgery (refers to the urinary organs of the body) that required skilled nursing care.

The facility MAR (Medication Administration Record) for May 2024 revealed Resident #39 was administered Amoxicillin 875 mg-give 1 tablet by mouth every 12 hours for UTI on 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/07/24, 05/08/24, 05/09/24, and 05/10/24 for a total of 14 doses.

In an interview with the Consultant Pharmacist on 6/12/24 at 9:50 AM she stated the difference between Amoxicillin and Amoxicillin-Clavulanate was that the addition of Clavulanate helped the Amoxicillin work better and more types of bacteria were affected. She would have expected the provider to be notified to report the medication error and determine if additional treatment was necessary.

In an interview with the Director of Nursing (DON) on 06/12/24 at 4:40 PM she stated she had not followed up on the pharmacy recommendation and had not notified the provider that the wrong antibiotic had been administered to Resident #39 to determine if further treatment was necessary.

In an additional interview with the DON on

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06/13/24 at 9:00 AM she stated the hall nurse was responsible for faxing the hospital discharge orders to the pharmacy. She concluded this was a medication error that was not caught, and these orders were not double checked by another nurse after they were put into the computer system. She reported she had not been able to get staff on board with the new "Homework" check list she had instituted for reviewing new orders.

In an interview with Pharmacy Tech #1 on 09/13/24 at 9:15 AM she stated the pharmacy had only received the orders for Resident #39 through the computer system and had not received a copy of the hospital discharge summary. If the pharmacy received a discharge summary for a new admission the discharge orders were checked against the orders entered into the computer system and if there were any differences the facility would be notified for a clarification. The pharmacy only reviewed the orders put into the system and would not have known there was a discrepancy. She stated this was a big disconnect with this facility and noted the error was caught on the next scheduled pharmacist review.

In an interview with Pharmacist #1 on 06/13/24 at 12:21 PM she stated she had completed the Medication Regimen Review for Resident #39 on 05/02/24 when he was admitted to the facility. She received the orders that had been entered into the computer system. She did not have a hospital discharge summary to compare the orders against. She explained if she had a discharge summary to compare the orders, she would have alerted the facility there was a difference between the orders entered into the computer system and the discharge summary

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orders. She added she did not receive discharge summaries from this facility very often.

In an interview with Unit Manager #2 on 06/13/24 at 8:34 AM she stated the discharge summary from the hospital came with the resident when admitted to the facility. She explained that the floor nurse entered the admission orders into the computer system from the discharge summary. It was not the facility policy for the floor nurse to call the provider to review the orders. All orders put into the computer system went directly to the pharmacy. The hospital discharge summary was to be faxed to the pharmacy by the floor nurse. The pharmacy would then fax the facility if the discharge summary orders did not match the orders put into the computer system. She explained it was the responsibility of the floor nurse to call the provider to clarify the orders if there were any differences. She stated no one had double checked new orders for the last 4 to 5 years that she had been the Unit Manager. She reported the new DON had recently implemented a check list to double check all new orders.

In an interview with the DON on 06/14/24 at 4:30 PM she stated she expected the floor nurses to fax hospital discharge summaries to the pharmacy and call the physician when alerted to any differences between the orders on the discharge summary and the orders entered into the computer. She also expected provider to be notified of any medication errors and pharmacy recommendations to be addressed.

In an interview with the facility physician on 06/19/24 at 9:30 AM she stated she had not been notified that Resident #39 was given the wrong antibiotic. She noted she had just started at the

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facility last week and was not his doctor when this occurred. However, she reported she had seen Resident #39 yesterday and he was not having any symptoms of a UTI at this time. She did not feel any further intervention was required. She stated she would expect to be notified whenever there was a pharmacy recommendation or a medication error so that it could be addressed when it occurred.

6. Resident #32 was admitted to the facility on 05/09/24 with diagnoses including major depression.

Review of the hospital discharge orders dated 05/09/24 for Resident #32 revealed to continue Mirtazapine 15 milligrams (mgs) at bedtime for major depression. Continue Venlafaxine (Effexor) 75 mg oral tablets extended release. Give 3 tablets (225 mgs) by mouth every morning for depression.

A care plan dated 05/10/24 revealed Resident #32 received antidepressant medications. Interventions included to administer medications as ordered by the physician.

The Minimum Data Set (MDS) admission assessment dated 05/15/24 revealed Resident #32 was cognitively intact. He had no behaviors and no rejection of care. He received antidepressant medication.

Review of the Medication Administration Record (MAR) dated May 2024 revealed no documentation that Mirtazapine 15 milligrams (mgs) at bedtime for major depression was ordered or administered to Resident #32 from 05/10/24 through 05/31/24. This resulted in 22

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missed doses.

Review of the Medication Administration Record (MAR) dated May 2024 revealed Resident #32 received the antidepressant medication Effexor 225 mgs beginning 05/10/24 at 8:00 AM. This medication was administered daily from 05/10/24 though 05/31/24.

Review of the Medication Administration Record (MAR) dated June 2024 revealed no documentation that Mirtazapine 15 milligrams (mgs) at bedtime for major depression was ordered or administered to Resident #32 from 06/01/24 through 06/12/24 the date the MAR was reviewed. This resulted in 12 missed doses.

Review of the Medication Administration Record (MAR) dated June 2024 revealed Resident #32 received the antidepressant medication Effexor 225 mgs daily at 8:00 AM.

A psychiatry evaluation note documented by the Psychiatrist dated 05/22/24 revealed in part; Resident #32 was evaluated due to staff reported depression. Resident #32 reported depression and anxiety. No aggressive behavioral outbursts reported, no delusional thoughts reported. No falls, no complaints with appetite. No reports of somnolence. He was compliant with medications and activities of daily living. He was referred for depression, anxiety, adjustment to the facility, and psychotropic medication management. The plan of care included to trial Melatonin (supplement) for sleep which may help with mood. Effexor was at maximum dosage but will consider adding Abilify (atypical antipsychotic) in the future as an adjunct for depression. No medication signs or symptoms were reported. Will continue to

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monitor.

During an interview on 06/10/24 at 1:30 PM Resident #32 was observed lying in bed. He was alert and oriented to person, place, and time. He easily engaged in conversation and stated he recently admitted to the facility and had no concerns with his care. He indicated he had a history of depression and had been on antidepressant medications in the past. He initially stated he had not been seen by Psychiatry however he later recalled talking with a "doctor" since he had been in the facility about his depression medication. He stated he did not like to engage in activities in the facility or go out of his room because he didn't like to be around other people and he had been that way for a long time. He indicated he was content staying in his room and in bed, but he would try to start getting out of bed more often. He reported he felt no different today as far as his mood compared to when he first came to this facility. He stated he was glad he was here and was happy that he had staff to take care of him. He reported that staff continually encouraged him to get out of bed daily and participate in activities, but he didn't want to. He stated he received medications, but he did not know exactly what medications he was on but indicated he did receive an antidepressant medication.

During an interview on 06/12/24 at 04:15 PM Nurse #7 stated she was routinely assigned to Resident #32 and was familiar with his care needs. She reported he was alert and oriented to person, place, and time but had periods of confusion. She stated he was cooperative with care but did not want to get out of the bed. She indicated Resident #32 had no behaviors, and he

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was compliant with taking his medications. She reported he had not expressed any concerns to her regarding depression except for the fact of not wanting to get out of bed each day but he had been like that since his admission to the facility. She indicated he received Effexor 225 mgs daily for depression but was not aware of an order for Mirtazapine 15 mgs daily. She reported there had been no change in his mood or behaviors since his admission.

During an interview on 06/12/24 at 04:37 PM Unit Manager #2 stated she was not aware that Resident #32 was ordered Mirtazapine 15 mgs at bedtime. She stated typically the residents assigned nurse was responsible for transcribing the admission orders from the hospital discharge summary but acknowledged that she was the nurse that entered Resident #32's admission orders into the electronic medical record on the day of his admission. She reported they had recently implemented a system in March or April of this year for the Unit Manager to do the 1st check and the Director of Nursing (DON) to complete a 2nd check to ensure the orders were transcribed accurately. Before that time the process had no 1st and 2nd check. She stated the Nurse Practitioner would also review medications when she did the initial evaluation, but the Nurse Practitioner did not sign the order sheets to ensure the medications were reviewed. She stated the Mirtazapine 15 mgs was just overlooked and she was responsible for the error. She indicated she was not sure if the Nurse Practitioner reviewed Resident #32's admission medication orders but the Nurse Practitioner had not reported any discrepancies to her. She stated Resident #32 had a history of depression, and staff had reported he had complaints of being

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depressed and they ordered Psychiatry services at that time. She stated he had no change in condition since his admission. She stated he was followed by the Psychiatrist and the Psychiatrist evaluated him last week.

During an interview on 06/13/24 at 11:59 AM the Consultant Pharmacist stated the starting dose of Mirtazapine was typically 7.5 to 15mg but when used for depression the dose goes up to 30 to 40 mgs per day. She stated there had been no dose increase according to the hospital notes. She stated due to Resident #32 being prescribed a low dose of Mirtazapine and receiving Effexor 225 mgs which was the maximum daily dose there would be no potential outcome of harm from not receiving 15 mgs of Mirtazapine.

During an interview on 06/13/24 at 12:35 PM the Psychiatrist stated she evaluated Resident #32 initially on 05/22/24. She stated Resident #32 had a history of depression and anxiety. She reported she was not aware of an admission order for Mirtazapine 15 mgs at bedtime for Resident #32, but she would most likely have discontinued the medication if he had been receiving it. She reported Mirtazapine 15 mgs was typically a starting dose with a maximum daily dose of 45 mgs per day. It was also used off label to treat a decline in appetite and induce weight gain. However Resident #32's BMI (body mass index) was high, and it would not have been prescribed for weight management. She reported she would have discontinued it due to Resident #32 receiving the maximum dose of Effexor and Effexor and Mirtazapine both having serotonin agents and due to polypharmacy, she typically did not initially prescribe both. She reported she evaluated Resident #32 again last week on

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06/07/24 and added a trial of Topamax (an anticonvulsant medication prescribed off label for depression) 25 mgs twice a day. She stated there would be no significant outcome or potential for harm from not receiving the Mirtazapine 15 mgs daily since his admission to the facility. She reported she had evaluated Resident #32 on two occasions since his admission in May, most recently last week and his mood was stable. She stated Resident #32 remained at his baseline. She indicated she was satisfied with the current plan of care and was not planning to add Mirtazapine 15 mgs to the treatment plan.

During an interview on 06/14/24 at 4:00 PM the Director of Nursing (DON) stated she was not aware Resident #32 had an order for Mirtazapine at bedtime when he was admitted. She stated the process was that the residents assigned nurse at the time of admission was responsible for entering medication orders, or the Unit Managers would enter orders. She stated they had implemented a new process once she became DON in March 2024 which involved completing a 1st and 2nd check by the unit managers or her to ensure the medications were transcribed accurately. She stated any discrepancy must be clarified by the physician by 5:00 PM that day or clarified by the hospital on the first day of admission. She indicated she did not complete a check of Resident #32's medications and was not aware of the discrepancy. She stated apparently their process was not working and education would be provided.

During an interview on 06/14/24 at 4:30 PM Unit Manager #2 indicated she was not aware of the medication discrepancy for Resident #32 and was not asked to review his medication orders to

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check for accuracy at the time of his admission.

Multiple attempts were made during the survey to contact the Nurse Practitioner and the Medical Director during the time Resident #32 was admitted. They were no longer employed by the facility, and there was no response.

7. Resident #10 was admitted to the facility on 03/09/22 with diagnoses including drug induced subacute dyskinesia (involuntary muscle movements that can range from slight tremors to uncontrollable movements of the body induced by psychotropic medications), and schizoaffective disorder.

A care plan dated 03/09/22 for Resident #10 revealed an alteration in neurological status related to Tardive Dyskinesia. Interventions included to administer medications as ordered.

A physician's order dated 03/06/24 for Resident #10 revealed Tetrabenazine 25 milligrams (mg) oral tablets. Give 2 tablets by mouth in the morning for Tardive Dyskinesia.

The Minimum Data Set (MDS) annual assessment dated 03/16/24 revealed Resident #10 had moderately impaired cognition. He exhibited no behaviors and no rejection of care. He received psychotropic medications.

The most recent Abnormal Involuntary Movement Scale (AIMS) assessment dated 03/21/24 revealed Resident #10 had a severity score of "2" which indicated mild severity.

Review of the Medication Administration Record (MAR) dated March 2024 revealed Resident #10

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received Tetrabenazine 25 mgs daily according to the physician's order.

Review of the Medication Administration Record (MAR) dated April 2024 revealed Resident #10 received Tetrabenazine 25 mgs daily according to the physician's order.

A Psychiatric evaluation note dated 04/10/24 written by the Psychiatrist revealed in part; no signs or symptoms of Tardive Dyskinesia such as tongue thrusts, blinking, or leg movements, only mild tremors noted.

Review of the Medication Administration Record (MAR) dated May 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily scheduled for administration at 9:00 AM had a chart code of "9" indicating the medication was not administered and to see the nursing progress notes on the following dates and time.

05/09/24 at 9:00 AM
05/10/24 at 9:00 AM
05/11/24 at 9:00 AM
05/12/24 at 9:00 AM
05/13/24 at 9:00 AM
05/15/24 at 9:00 AM
05/17/24 at 9:00 AM
05/18/24 at 9:00 AM
05/20/24 at 9:00 AM
05/24/24 at 9:00 AM
05/25/24 at 9:00 AM
05/26/24 at 9:00 AM
05/27/24 at 9:00 AM
05/28/24 at 9:00 AM
05/30/31 at 9:00 AM
05/31/24 at 9:00 AM

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Review of the nursing progress notes from 05/09/24 through 05/31/24 for Resident #10 revealed no documentation as to why the Tetrabenazine 25 mg tablets were not administered according to the physician's order.

Review of the Medication Administration Record (MAR) dated June 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily scheduled for administration at 9:00 AM had a chart code of "9" indicating the medication was not administered and to see the nursing progress notes on the following dates:

06/03/24
06/05/24
06/07/24
06/08/24
06/10/24
06/11/24
06/12/24

Review of the nursing progress notes from 06/03/24 through 06/12/24 for Resident #10 revealed no documentation as to why the Tetrabenazine 25 mg tablets were not administered according to the physician's order.

A Psychiatric evaluation note dated 06/07/24 written by the Psychiatrist revealed in part; no signs or symptoms of Tardive Dyskinesia such as tongue thrusts, blinking, or leg movements, only mild tremors noted.

An interview and observation was conducted on 06/11/24 at 12:30 PM with Resident #10. He was observed sitting up on the side of his bed. He was

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alert, and oriented to person, place, and month. He was not aware of what medications he received daily. Mild bilateral hand tremors were noted with no other symptoms of Tardive Dyskinesia observed.

During an interview with Nurse #7 on 06/12/24 at 3:00 PM she stated Resident #10 had been out of the Tetrabenazine 25 mgs for a while, and they were waiting on Pharmacy to refill the medication. She reported that she called the pharmacy yesterday on 06/12/24 to ask about the medication and they informed her they were waiting for the prior authorization form to be returned from the facility before they could refill the medication. She stated the Pharmacy reported to her they would send over another authorization form through fax, but she had not been notified today if the fax was received here at the facility. She stated she was routinely assigned to Resident #10, he was independent with limited supervision with activities of daily living (ADL) and ambulated around the facility daily with a cane. She reported she had not observed any symptoms of Tardive Dyskinesia except for mild tremors which was his baseline and there had been no change in his condition.

During a phone interview on 06/13/24 at 2:00 PM Pharmacy Technician #1 stated the initial order for Tetrabenazine 25 mgs for Resident #10 was originally filled and sent to the facility on 03/06/24. The Pharmacy dispensed 60 tablets which was a 30-day supply. She stated they dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed anymore of the medication since 04/06/24 because they needed to get prior authorization to continue to fill the medication. She stated a prior authorization

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form was faxed to the facility on 05/06/24 when it was due to be refilled again. She reported the last correspondence received from the facility regarding the medication was on 05/24/24 and another prior authorization form was faxed to the facility that day and had not been received back to the Pharmacy. She stated the process for medication authorization forms was that a form was faxed to the facility and the facility would have the physician authorize a refill of the medication or change the medication to a drug that was covered by the residents insurance. She reported the turnaround time depended on how long it took the physician and the facility to complete the form and get it back to the Pharmacy. She stated according to the Pharmacy record they had not received the prior authorization from the facility and therefore had not sent the medication. She reported it was the facility's responsibility to ensure the forms were sent back to the Pharmacy.

During an interview on 06/13/24 at 2:15 PM the Consultant Pharmacist stated Resident #10 was prescribed Tetrabenazine for Tardive Dyskinesia. She reported he had received another medication to treat Tardive Dyskinesia prior to the order for Tetrabenazine. She stated according to the Pharmacy records they were waiting on the prior authorization form before they could dispense Tetrabenazine again due to the high cost of the medication. She stated the only symptoms noted in the medical record were mild tremors. She reported that she addressed this issue on the medical record review she completed 05/26/24. She indicated she followed up with the Director of Nursing (DON) today when she came to the facility to complete her monthly review and it was determined the authorization form had not been

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sent back to the Pharmacy. She indicated typically she expected to see follow up on medication irregularities that she reported to the facility within 30 days. She stated there would be no significant outcome from not receiving the missed doses of Tetrabenazine, it would only cause him to continue having symptoms but indicated mild tremors were baseline for him.

During an interview on 06/13/24 at 3:30 PM the Director of Nursing (DON) stated the Nurse Practitioner and Physician who prescribed the Tetrabenazine were no longer working for the facility. She stated she was not aware Resident #10 did not have the Tetrabenazine until today and was not aware the Pharmacy was waiting on a prior authorization form. She indicated the authorization form should have been completed and returned to the Pharmacy when the form was received in the facility, but she was not aware of when the form was received at the facility. She reported Resident #10 should not have missed the number of doses due to the miscommunication and education would be provided. She reported the process should have been that once the form was faxed to the facility it was given to the Physician or the Nurse Practitioner to review and sign. Then the Physician or Nurse Practitioner was to notify the DON whether the medication was approved for refill or changed to a covered medication. She stated this did not occur. She stated she typically gave the medication authorization forms to Unit Manager #2 who was responsible for giving the form to the Physician or Nurse Practitioner then faxing the signed form to the Pharmacy. She stated she assumed the forms were getting faxed back to the Pharmacy.

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Multiple Attempts were made during the investigation to contact the previous Physician and Nurse Practitioner and there was no response.

During a phone interview on 06/18/24 at 10:06 AM the Psychiatrist stated she last evaluated Resident #10 on 06/07/24. She stated the Tetrabenazine was prescribed by the facility Nurse Practitioner who no longer worked at the facility. She stated she noted in her evaluation on 06/07/24 that Resident #10 was on Tetrabenazine for Tardive Dyskinesia, but she was not aware he had not received the medication since the beginning of May 2024. She stated staff had reported to her in the past that Resident #10 had symptoms of Tardive Dyskinesia such as tongue thrust, and leg movements but indicated during her evaluation on 02/14/24, 04/10/24, and most recently on 06/07/24 she only observed mild tremors and no other symptoms of Tardive Dyskinesia. She typically did not prescribe Tetrabenazine, and it needed prior authorization from the insurance company due to the high cost of the medication. She stated due to Resident #10 not having ongoing symptoms of Tardive Dyskinesia and only mild tremors there would be no significant outcome from not receiving the medication and stated the medication did not cause withdrawal symptoms after it was stopped. She indicated there had been no change in his condition.

8. Resident #50 was admitted to the facility on 10/06/23. Diagnoses included, in part, coronary artery disease, high blood pressure, chronic kidney disease, and congestive heart failure.

The Minimum Data Set (MDS) quarterly

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assessment dated 02/20/24 revealed Resident #50 was cognitively intact.

A review of a physician's order written on 10/06/23 revealed give one tablet of Carvedilol (a medication to treat coronary artery disease) 12.5 milligrams twice daily and to hold medication for a heart rate less than 60 bpm or systolic blood pressure (SBP) less than 110 mg/Hg and administer with meals.

A review of Resident #50's medication administration record (MAR) for May 2024 to administer the Carvedilol 12.5 milligrams revealed the following:

05/11/24 the blood pressure recording was 100/59 mm/Hg and the heart rate recording was 59 bpm at 9:00 AM and was signed off by Unit Manager #1

05/15/24 the blood pressure recording was 106/68 mm/Hg at 9:00 AM and was signed off by Nurse #9
05/26/24 the blood pressure recording was 109/63 mm/Hg at 5:30 PM and was signed off by Unit Manager #1
05/27/24 the blood pressure recording was 103/69 mm/Hg at 5:30 PM and was signed off by Unit Manager #1

A review of Resident #50's medication administration record (MAR) for June 2024 to administer the Carvedilol 12.5 milligrams revealed the following:

06/04/24 the blood pressure recording was 106/64 mm/Hg at 9:00 AM and was signed off by Medication Aide (MA) #3

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06/08/24 the blood pressure recording was 108/69 mm/Hg at 9:00 AM and was signed off by MA #3
06/08/24 the blood pressure recording was 96/60 mm/Hg at 9:00 AM and at 5:30 PM and was signed off by Unit Manager #1
06/10/24 the blood pressure recording was 91/58 mm/Hg at 9:00 AM and was signed off by MA #3.

An interview was conducted with the Pharmacist Consultant on 06/11/24 via phone at 11:20 AM. The Pharmacist Consultant stated if there were parameters given in an order, the expectation was that the blood pressure medication would be held according to the physician's order if the reading was outside the parameters. She stated the resident would be at risk for increased hypotension (low blood pressure) or bradycardia (decreased heart rate) if the medication was given.

An interview was conducted with Unit Manager #1 on 06/14/24 at 1:17 PM. UM #1 reported the initials on the medication administration record for May and June were hers and the check mark meant she gave the medication. She stated if she signed off in the MAR and there was a checkmark, then she gave it and she should have held it according to the physician's order. The Unit Manager stated it was important to follow the parameters of the physician's order to prevent the resident's blood pressure and heart rate from getting too low.

An interview was conducted with Medication Aide #3 on 06/14/24 at 2:15 PM. MA #3 reported the initials on the medication administration record for June were hers and the check mark meant she gave it. She stated if she signed off in the MAR

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and there was a checkmark, then she gave it and she should have held it due to the parameters.

An interview was conducted with Nurse #9 via phone on 06/18/24 at 5:30 PM. She reported whenever there was a checkmark and nursing initials on the MAR it meant that it was administered. She stated if her initials and checkmark were on the MAR on 05/15/24, then she administered the medication.

An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 5:00 PM. The DON revealed the nursing staff should be checking their blood pressure and heart rate prior to administering the medication. She added, if the vital signs were outside of the parameters and the order stated to hold the medication, the medication should be held. The DON stated giving the medication when the blood pressure or heart rate was low could put the resident at risk for lowering their blood pressure and heart rate unnecessarily.

9. Resident #8 was admitted to the facility on 8/19/23 with diagnoses which included chronic atrial fibrillation, Type 2 Diabetes Mellitus, and pain.

Resident #8's quarterly Minimum Data Set (MDS) Assessment dated 5/24/24 indicated she was cognitively intact.

a. Physician's orders for Resident #8 dated 2/28/24 indicated:
- Oxycodone/Acetaminophen 10/325 mg - 1 tablet by mouth two times a day for pain.
- Oxycodone/Acetaminophen 5/325 mg - 1 tablet by mouth one time a day for pain

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Resident #8's physician's orders did not include an order for routine pain monitoring.

Resident #8's MAR from 2/28/24 through 6/12/24 revealed the resident received Oxycodone/Acetaminophen 5/325 mg as ordered by physician.

A Nurse Practitioner note (NP) dated 4/16/24 at 8:00 am indicated Resident #8 had concerns about her pain medication refills. The note further indicated the NP explained and showed to the primary nurse an order from pharmacy indicating the medication was dispensed.

An attempt was made to interview NP via phone with messages left on 7/1/24 at 3:45 pm with no return call received.

The April 2024 MAR indicated Resident #8's Oxycodone/Acetaminophen 10/325 mg was scheduled to be administered at 8:00 am and 8:00 pm. This MAR and the medication administration notes revealed the following related to Resident #8's Oxycodone/Acetaminophen 10/325 mg:

The Medication Administration Record (MAR) specified the documentation of a "9" indicated to see the nursing notes.

4/16/24
- The MAR for 8:00 pm indicated Nurse #2 documented a "9" and there was no corresponding nursing note.
4/18/24
- The MAR for 8:00 am indicated Nurse #6 documented a "9" and the corresponding record

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note at 9:06 am indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
- The MAR for 8:00 pm indicated Nurse #9 documented a "9" and the corresponding record note at 9:36 pm indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy
4/19/24
- The MARfor 8:00 am indicated Nurse #9 documented a "9" and the corresponding record note at 12:53 pm indicated Resident #8 was out of the facility with her husband and friend for lunch.
- The MAR for 8:00 pm indicated Nurse #8 documented a "9" and the corresponding record note at 8:42 pm indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
4/20/24
- The MAR for 8:00 am indicated Medication Aide (MA #5) documented a "9" and there was no corresponding nursing note.
4/21/24
- The MAR for 8:00 am indicated MA #5 documented a "9" and there was no corresponding nursing note.
4/22/24
- The MAR for 8:00 am indicated Nurse #6 documented a "9" and the corresponding record note at 9:34 am indicated the facility was awaiting the arrival of Oxycodone/Acetaminophen 10/325 mg from the pharmacy.
- The MAR for 8:00 pm indicated Nurse #8 documented a "9" and the corresponding record note at 8:53 pm indicated the medication was on order.
4/23/24
- The MAR for 8:00 am indicated Nurse #19

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documented a "9" and the corresponding record note at 9:46 am indicated the medication was not on hand and had been ordered.
- The MAR for 8:00 pm indicated Nurse #8 documented a "9" and the corresponding record note at 8:38 pm indicated the medication was on order from the pharmacy.
4/24/24
- The MAR for 8:00 am indicated Nurse #9 documented a "9" and there was no corresponding nursing note.

During a phone interview on 7/1/24 at 11:51 am with Nurse #8, she indicated Resident #8 did not have her scheduled 8:00 pm Oxycodone 10/325 mg available on 4/19/24 and 4/23/24. She indicated in her nursing documentation she was awaiting delivery from the pharmacy. She further stated Resident #8 did not voice any complaints of pain.

During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8's medication was not available on the medication cart. She indicated the medication had been ordered. She further stated Resident #8 did not voice any complaints of pain.

Attempts were made to interview Nurse #9 via phone with messages left on 6/28/24 with no return call received. Nurse #9 no longer worked at the facility.

Attempts were made to interview Nurse #2 by phone with messages left on 6/28/24 with no return call received.

Attempts were made to interview MA #5 by phone with messages left on 6/28/24 with no return call

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received.

The June 2024 MAR and the medication administration notes revealed the following related to Resident #8's Oxycodone/Acetaminophen 10/325 mg:

6/2/24
- The MAR for 8:00 am indicated Medication Aide (MA #3) documented a "9" and the corresponding administration record note at 12:39 pm indicated the medication was not on hand and had been ordered.

During a phone interview with MA #3 on 6/28/24 at 12:21 pm she indicated the medication was not available in the narcotic drawer on the medication cart on 6/2/24 and she documented she was waiting for the medication to be delivered from the pharmacy. Resident #8 did not voice any complaints of pain.

Resident #8 was interviewed on 6/12/24 at 8:30 am, she indicated she was unable to recall when she spoke to the DON regarding not receiving her pain medication. She stated she spoke to the previous NP on 4/16/24 regarding not receiving her pain medication. She indicated the previous NP explained the medication had been dispensed by the pharmacy.

In an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am, she indicated she was aware of Resident #8's concerns related to not receiving her pain medication. She further stated there was a problem with the medications not being available. She indicated she expected the nurses to administer the pain medications as ordered by the physician.

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During a phone interview with the Administrator on 6/28/24 at 4:10 pm, she stated she expected pain medication to be administered as ordered by the physician.

b. A physician's order for Resident #8 dated 9/22/23 indicated Ozempic 0.25 or 0.5 milligrams (mg) - inject 1 mg subcutaneously (under the skin) one time a day every Friday for type 2 Diabetes Mellitus.

The April 2024 Medication Administration Record (MAR) indicated Resident #8's Ozempic was scheduled to be administered at 8:00 am every Friday. This MAR and the medication administration notes revealed the following related to Resident #8's Ozempic:

4/5/24
- The MAR for 8:00 am indicated Nurse #9 documented a "9" and the corresponding administration record note at 10:56 am indicated the medication had been ordered.

4/19/24
- The MAR for 8:00 am indicated Nurse #9 documented a "9" and the corresponding administration record note at 7:53 am did not indicate why the medication was not given.

Attempts were made to interview Nurse #9 via phone with messages left on 6/28/24 with no return call received. Nurse #9 no longer worked at the facility.

The May 2024 MAR and the medication administration notes revealed the following related to Resident #8's Ozempic:

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5/17/24
- The MAR for 8:00 am indicated Nurse #7 documented a "9" and the corresponding administration record note at 9:17 am indicated the medication was on order.

An interview with Nurse #7 on 6/12/24 at 2:50 pm revealed she ordered the Ozempic on 5/17/24 and was told it would be delivered to the facility that night. She further revealed she passed this information in report to the on-coming night nurse but was unsure if the injection was given by the night nurse.

e. A physician's order for Resident #8 dated 8/19/23 indicated Rivaroxaban (anticoagulant)15 mg - 1 tablet by mouth in the evening for atrial fibrillation.

The May 2024 MAR and the medication administration notes revealed on 5/30/24 MA#5 documented a "9" and there was no corresponding administration record note.

Attempts were made to interview MA #5 by phone with messages left on 6/28/24 with no return call received.

e. A physician's order for Resident #8 dated 8/19/23 indicated Glipizide 10 mg - 1 tablet by mouth two times a day for type 2 Diabetes Mellitus.

The May 2024 MAR and the medication administration notes for 5/19/24 for Resident #8's 8:00 am dose of Glipizide indicated Unit Manager #2 documented a "9" and the corresponding administration record note at 10:41 am indicated

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F 760	Continued From page 299 the facility was awaiting the arrival of Glipizide 10 mg from the pharmacy. In an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am, she stated there was a problem with the medications not being available. She further stated she expected the nurses to administer all medications as ordered by the physician. A phone interview with the Medical Director on 6/17/24 at 11:21 am indicated missing diabetic medications was not optimal but had no serious adverse effects. She further stated missing anticoagulant medications adverse outcome would possibly be having a stroke. She also stated missing pain medication would possibly be having increased pain.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		7/27/24

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F 761	Continued From page 300 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to: discard 10 doses of COVID-19 vaccine and a bottle of senna syrup (a liquid laxative medication) that were expired in the South station medication room for 1 of 2 medication rooms reviewed. The facility failed to store an unopened bottle of eye drops in the refrigerator per manufacturer's instructions on the 400-hall medication cart. The facility failed to dispose of 4 bottles of expired eye drops and had an in use inhaler with no resident name, opened date or expiration date on the 200 Hall medication cart. The facility failed to label a tube of eye ointment with an opened and expiration date and failed to discard an expired bottle of atropine solution on the 300 Hall medication cart. This was for 3 of 3 medication carts observed for medication storage. Findings included: 1a. Observation of the South station medication room was conducted on 6/11/24 at 2:30 PM with Unit Manager #1 in attendance. The following expired medications were observed: 14 doses of COVID-19 vaccine were observed with a printed expiration date of 6/2/24 on the box.	F 761	The facility failed to discard 10 doses of COVID-19 vaccine and a bottle of senna syrup that were expired in the South Station medication room for 1 of 2 medication rooms reviewed. The facility failed to store an unopened bottle of eye drops in the refrigerator per manufacturer's instructions on the 400-Hall medication cart. The facility failed to dispose of 4 bottles of expired eye drops and had an in-use inhaler with no resident name, opened date, or expiration date labeled on the 200-Hall medication cart. The facility failed to label a tube of eye ointment with an opened and expiration date and failed to discard an expired bottle of atropine solution on the 300-Hall medication cart. This was for 3 of 3 medication carts observed for medication storage. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice.	

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F 761	Continued From page 301 8-ounce bottle of Senna syrup with a printed expiration date of 4/24/24 on the label. An interview was conducted with Unit Manager #1 on 6/11/24 at 2:30 PM revealed the nurses on the medication carts were to check for expired medications on the carts. Unit Manager #1 stated the pharmacist checked one of the medication carts each time on her monthly visit. 1b. Observation of the 400-hall medication cart on 6/11/24 at 3:00 PM with Unit Manager #1 in attendance revealed: Resident #421's unopened bottle of latanoprost .005% eye drops with a label which indicated refrigerate until opened. The unopened bottle was noted in the top drawer of the medication cart not refrigerated. An interview was conducted on 6/11/24 at 3:30 PM with Nurse #7. Nurse #7 indicated the Unit Managers asked the nurses to check the medication carts for expired medications and eye drops that required refrigeration, but she did not know who was responsible for making sure it was done. 1c. Observation of the 200-hall medication cart on 6/11/24 at 3:30 PM with Medication Aide (MA) #3 in attendance revealed: Resident #14's opened bottle of Vyzulta 0.024% ophthalmic solution with a date opened of 4/22/24. According to the manufacturer's expiration information, it was good for 8 weeks after opening, or 6/10/24. Resident #24's dorzolamide/timolol ophthalmic	F 761	The Director of Nursing (DON) or Designee will review all medication carts to ensure all expired medications are disposed of appropriately, all opened eye drops are labeled and store appropriately, all inhalers are labeled appropriately, and will ensure all unopened eye drops are stored per the manufacturers instructions by 8/5/2024. The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the appropriate storage of medications, to include unopened eye drops, as well as appropriate labeling of all opened medications. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will audit all medication carts 3 times per week x 12 weeks to ensure all expired medications are disposed of appropriately, all medications are stored appropriately, and all opened medications are labeled. Any expired medications found, and/or labels missing will result in re-education and additional training for the appropriate nursing staff. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI	

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F 761	Continued From page 302 solution 2-0.5% with a date opened of 4/24/24. The manufacturer instructions indicated to discard 4 weeks after opening. or 28 days, which was 5/22/24. Resident #24's latanoprost 0.005% ophthalmic solution with a handwritten date opened of 5/3/24 and an expiration date of 5/31/24. The manufacturer's instructions indicated to discard 4 weeks, or 28 days after opening. Resident #30's latanoprost 0.005% ophthalmic solution with a handwritten date opened of 5/2/24 and an expiration date of 6/2/24. The manufacturer's instructions indicated to discard 4 weeks or 28 days after opening. An in-use Ventolin inhaler was found on the medication cart with no resident name or dose. There was no label with a date opened or an expiration date. 1d. Observation of the 300-hall medication cart on 6/11/24 at 3:45 PM with MA#3 in attendance revealed: Resident #169's ciloxan ophthalmic ointment 0.3% with no date opened and no expiration date on the label. Resident #20's atropine solution 1% use 1 drop under the tongue every 3 hours as needed. The bottle had a handwritten date opened of 5/9/24 and an expiration date of 6/9/24. An interview was conducted on 6/11/24 at 3:47 PM with MA # 3. MA # 3 indicated she was new to working on the medication cart, so she was not sure, but she thought the Unit Managers checked	F 761	Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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F 761	Continued From page 303 the medication carts. An interview was conducted with the Director of Nursing (DON) on 6/11/24 at 4:05 PM. The DON stated her expectation was that there would be no expired medications on the medication carts or in the medication rooms. The DON further stated there was a breakdown in the process for checking the medication carts for expired medications and checking that medications were labeled and dated.	F 761		
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. §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-	F 842		7/27/24

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(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 305 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Pharmacy Technician, and Consultant Pharmacist interviews the facility failed to accurately document on the Medication Administration Record (MAR) the administration of medications for 2 of 10 residents (Resident #10 and Resident #8) reviewed for medications. Findings included. 1. A physician's order dated 03/06/24 for Resident #10 revealed Tetrabenazine 25 milligrams (mg) oral tablets. Give 2 tablets by mouth in the morning for Tardive Dyskinesia. Review of the Medication Administration Record (MAR) dated May 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily at 9:00 AM was signed off as administered on the following dates and time. 05/14/24 at 9:00 AM 05/16/24 at 9:00 AM 05/19/24 at 9:00 AM 05/21/24 at 9:00 AM 05/22/24 at 9:00 AM 05/23/24 at 9:00 AM 05/29/24 at 9:00 AM Review of the Medication Administration Record (MAR) dated June 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily at 9:00 AM was signed off as administered on the following dates and time. 06/01/24 at 9:00 AM	F 842	The facility failed to accurately document on the Medication Administration Record (MAR) the administration of medications for 2 of 10 residents (Resident #10 and Resident #8) reviewed for medications. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee will review the MAR for the 2 residents involved by 8/5/2024, to ensure medication administration is being documented appropriately. The DON or Designee will educate all nurses and medication aides by 8/5/2024 on the importance of documenting medications as they are being administered, to ensure all medications are given as ordered by the provider. After 8/5/2024 newly hired nursing staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will audit a MAR 5 times per week for 12 weeks to ensure all medication administrations are being documented accurately. Any medication administrated that is not documented will result in re-education and additional training for the appropriate nursing staff.	

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F 842	Continued From page 306 06/02/24 at 9:00 AM 06/04/24 at 9:00 AM 06/06/24 at 9:00 AM 06/09/24 at 9:00 AM During a phone interview on 06/13/24 at 2:00 PM Pharmacy Technician #1 stated the initial order for Tetrabenazine 25 mgs for Resident #10 was originally filled and sent to the facility on 03/06/24. The Pharmacy dispensed 60 tablets which was a 30-day supply. She stated they dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed anymore of the medication since 04/06/24 because they needed to get prior authorization to continue to fill the medication. She stated they did not refill the medication after 05/06/24 and indicated the medication would not have been available in the facility for administration after 05/06/24. During an interview on 06/13/24 at 2:15 PM the Consultant Pharmacist stated according to the pharmacy records Tetrabenazine 25 mgs had not been dispensed from the pharmacy since 05/06/24 due to waiting on a prior authorization form. She indicated the medication would not have been available in the facility for administration after 05/06/24. During an interview on 06/12/24 at 3:00 PM Nurse #7 stated Resident #10 had been out of the Tetrabenazine 25 mgs for a while, and they were waiting on pharmacy to refill the medication. She reported that she called the pharmacy yesterday on 06/12/24 to ask about the medication and they informed her they were waiting for the prior authorization form to be returned from the facility before they could refill the medication. She stated if she signed off on	F 842	Beginning 7/27/2024, the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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the MAR that the Tetrabenazine 25 mgs was administered to Resident #10 on 06/06/24 when the medication was not in the facility then it was done in error.

During an interview on 06/13/24 at 3:25 PM Unit Manager #2 stated she didn't know why she signed off on the MAR that she administered Tetrabenazine 25 mgs to Resident #10 on 05/16/24, 05/22/24, 05/29/24, 06/01/24, 06/02/24, and 06/09/24 when the medication was not in the facility. She indicated it was done in error.

During an interview on 06/13/24 at 3:49 PM Nurse #6 stated if she signed off on the MAR that she administered Tetrabenazine 25 mgs to Resident #10 on 05/21/24 when the medication was not in the facility then it was done in error.

An attempt was made to contact Nurse #9 on 06/13/24 at 04:01 PM Nurse #9 documented on the MAR that she administered Tetrabenazine 25 mgs to Resident #10 on 05/23/24 when the medication was not in the facility. There was no response.

During an interview on 06/14/24 at 10:57 AM Unit Manager #1 stated if she signed off on the MAR that the Tetrabenazine 25 mgs was administered to Resident #10 on 05/14/24 when the medication was not in the facility then it was done in error.

During a phone interview on 06/14/24 at 3:00 PM Nurse #19 stated if she signed off on the MAR that the Tetrabenazine was administered to Resident #10 on 05/19/24 when the medication was not in the facility then it was done in error.

During an interview on 06/14/24 at 3:30 PM the

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Director of Nursing (DON) stated she was not aware that Resident #10 did not have Tetrabenazine available during May and June 2024. She reported the nurses should not have signed off on the MAR that the medication was administered if they didn't have the medication in the facility.

During an interview on 06/14/24 at 3:30 PM the Administrator stated she expected that the nurses were accurately documenting medication administration on the residents MAR. She stated education would be provided.

2. Resident #8 was admitted to the facility on 8/19/23 with diagnoses which included chronic atrial fibrillation, Type 2 Diabetes Mellitus, and pain.

Resident #8's quarterly Minimum Data Set (MDS) Assessment dated 5/24/24 indicated she was cognitively intact.

Review of the physician orders for Resident #8 revealed the following:
8/19/23: Rivaroxaban 15 mg - 1 tablet by mouth in the evening for atrial fibrillation
8/19/23: Glipizide 10 mg - 1 tablet by mouth two times a day for type 2 Diabetes Mellitus
2/28/24: Oxycodone/Acetaminophen 5/325 mg - 1 tablet by mouth one time a day for pain
2/28/24: Oxycodone/Acetaminophen 10/325 mg - 1 tablet by mouth one time a day for pain

a. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 10/325 mg was scheduled to be administered at 8:00 am and 8:00 pm. This MAR and the medication

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administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen:

4/6/24 at 8:00 pm
4/7/24 at 8:00 am
4/7/24 at 8:00 pm

During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medication for Resident #8 but forgot to document in EMR the medication was given. The narcotic count sheet reviewed indicated her signature at 8:00 am.

In an interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she could not recall if she gave this medication on at 8:00 pm. The narcotic count sheet reviewed indicated her signature at 8:00 pm for the medication.

b. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 5/325 mg was scheduled to be administered at 2:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen:

4/7/24 at 2:00 pm
4/16/24 at 2:00 pm
4/19/24 at 2:00 pm

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During a phone interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medication for Resident #8 but forgot to document in EMR the medication was given. The narcotic count sheet reviewed indicated her signature at 2:00 pm.

c. The May 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 5/325 mg was scheduled to be administered at 2:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen:

5/11/24 at 2:00 pm
5/30/24 at 2:00 pm

d. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 5/325 mg was scheduled to be administered at 2:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen:

6/6/24 at 2:00 pm

e. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Rivaroxaban 15 mg was scheduled to be administered at 6:00 pm. This MAR and the

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medication administration notes revealed no medication documentation related to Resident #8's Rivaroxaban:

4/7/24at 6:00 pm
4/16/24 at 6:00 pm
4/19/24 at 6:00 pm
4/20/24 at 6:00 pm
4/21/24 at 6:00 pm
4/24/24 at 6:00 pm
4/29/24 at 6:00 pm

During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medication for Resident #8 but forgot to document in EMR the medication was given.

In an interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she could not recall if she gave this medication on 4/21/24 at 6:00 pm.

f. The May 2024 Medication Administration Record (MAR) indicated Resident #8's Rivaroxaban 15 mg was scheduled to be administered at 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Rivaroxaban:

5/5/24 at 6:00 pm
5/9/24 at 6:00 pm
5/10/24 at 6:00 pm
5/11/24 at 6:00 pm

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F 842	Continued From page 312 5/21/24 at 6:00 pm 5/22/24 at 6:00 pm 5/27/24 at 6:00 pm 5/29/24 at 6:00 pm In an interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she did not recall if she gave this medication on 6/9/24 at 6:00 pm. g. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Rivaroxaban 15 mg was scheduled to be administered at 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Rivaroxaban: 6/2/24 at 6:00 pm 6/9/24 at 6:00 pm During a phone interview with MA #3 on 6/28/24 at 12:31 pm, she stated the Rivaroxaban was not given. She further stated she was unable to administer this specific medication. She informed Unit Manager #1, the nurse covering her, that she did not give this medication. In a phone interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she did cover the medication aides working on the medication carts, but she could not recall if she gave this medication on 6/9/24 at 6:00 pm. During a phone interview with MA #6 on 6/28/24 at 12:48 pm, she indicated she was an MA and an NA at the facility. She indicated on 6/9/24 she was performing the job responsibilities of an MA and had given the medication but could not recall if she had documented administration in the	F 842		

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computer.

h. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Glipizide 10 mg was scheduled to be administered at 8:00 am and 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Glipizide:

4/7/24 at 8:00 am
4/7/24 at 6:00 pm
4/16/24 at 6:00 pm
4/19/24 at 6:00 pm
4/20/24 at 6:00 pm
4/21/24 at 6:00 pm
4/24/24 at 6:00 pm
4/29/24 at 6:00 pm

During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medications for Resident #8 but forgot to document in EMR the medications were given.

i. The May 2024 Medication Administration Record (MAR) indicated Resident #8's Glipizide 10 mg was scheduled to be administered at 8:00 am and 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Glipizide:

5/5/24 at 6:00 pm
5/9/24 at 6:00 pm
5/10/24 at 6:00 pm

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F 842	Continued From page 314 5/11/24 at 6:00 pm j. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Glipizide 10 mg was scheduled to be administered at 8:00 am and 6:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Glipizide: 6/2/24 at 6:00 pm 6/9/24 at 6:00 pm During a phone interview with MA #3 on 6/28/24 at 12:31 pm, she stated she does not recall if she administered this medication. During a phone interview with MA #6 on 6/28/24 at 12:48 pm, she indicated she was an MA and an NA at the facility. She indicated on 6/9/24 she was performing the job responsibilities of an MA and had given the medication but could not recall if she had documented administration in the computer. k. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Ozempic was scheduled to be administered at 8:00 am every Friday and specified. This MAR and the medication administration notes revealed no medication administration related to Resident #8's Ozempic: 6/7/24 at 8:00 am In an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am, stated there was a problem in the facility with the nurses documenting "9" on the MAR for medications not	F 842		

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F 842	Continued From page 315 available. She indicated she was trying to hold the nurses accountable for accurate medication documentation. During a phone interview with the Administrator on 6/28/24 at 4:10 pm, she stated she expected pain medication to be administered as ordered by the physician.	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 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	F 849		7/27/24

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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 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

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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.

§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

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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.
(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

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PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 849	Continued From page 319 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 record review, staff interviews, and hospice staff interviews the facility failed to maintain communication and coordination of services provided by hospice in the medical record complete with hospice admission documentation, hospice plan of care, and hospice visit notes in the facility's electronic medical record and failed to obtain physician orders for hospice services for 1 of 1 resident reviewed for hospice (Resident #48). Findings included: Resident #48 was admitted to the facility on 05/03/24 with diagnoses that included congestive heart failure, dementia, seizures, and edema. Review of Resident #48's Admission Minimum Data Set (MDS) assessment dated 05/09/24 revealed Resident #48 had moderate cognitive impairment. Resident #48 was coded as receiving Hospice services while a resident. A review of Resident #48's medical record revealed no evidence of the following: physician order for hospice services, hospice plan of care, facility hospice care plan, hospice certification	F 849	The facility failed to maintain communication and coordination of services provided by hospice in the medical record complete with hospice admission documentation, hospice plan of care, and hospice visit notes in the facility's electronic medical record and failed to obtain physician orders for hospice services for 1 of 1 resident reviewed for hospice (Resident #48). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) or Designee, will review all residents charts who are receiving hospice services by 8/5/2024 to ensure they have a physicians order for hospice services, as well as to ensure the hospice notes are uploaded into the residents charts with up-to-date documentation. The DON or Designee will review	

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F 849	Continued From page 320 statement, hospice nursing visit record forms, and no election of hospice form. The only documented hospice record found for Resident #48 were seven (7) notes written by facility nurses regarding hospice visits, but no hospice notes were present in resident's medical record. An interview was conducted on 06/13/24 at 9:35 AM with the Director of Nursing (DON). She revealed that it was her expectation that Hospice should have communicated more fully to facility staff. She said hospice failed to provide them with Resident #48's complete hospice record complete with hospice admission documentation, hospice plan of care, hospice visit notes, and documented hospice physician order. The DON said it was her expectation that there be a complete verbal and paper communication process between hospice and her nursing staff, and there was not. The DON then said she was ultimately responsible for not following up with Hospice as she should have, and for the facility not having a clear process in place to obtain and scan resident's Hospice medical records timely into their electronic medical record. An interview was conducted on interview with Medical Records on 06/13/24 at 10:10 AM. Medical Records confirmed Resident #48 was under Hospice care since 05/03/24. Medical Records stated she had not received: a resident hospice comprehensive care plan, hospice admission documentation, and hospice physician's order for hospice services. She indicated these documents should have been provided by the Hospice and were not. An interview was conducted on 06/13/24 at 10:24 AM with Hospice Nurse #12. She stated	F 849	Resident #48's medical record to ensure there is communication and coordination of services provided by hospice in the medical record complete with hospice admission documentation, hospice plan of care, and hospice visit notes in the facility's electronic medical record (EMR) and obtain physician orders for hospice services by 8/5/2024 if it is not already ordered or submitted in the EMR. The LNHA, DON, or Designee will educate the Medical Records Clerk and Admissions Coordinator by 8/5/2024 on the importance of uploading hospice notes in a timely manner and ensuring all hospice documentation for the resident is received to the facility upon admission and continuously once admitted to the facility while receiving hospice services. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will educate the nurse managers on the requirement to enter a physicians order for hospice services for all involved residents by 8/5/2024. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The LNHA, DON, or Designee will audit all hospice residents charts 3 times per week x 12 weeks to ensure the medical record includes all up-to-date hospice notes. Any missing documents that are not uploaded will result in re-education and additional	

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F 849	Continued From page 321 Resident #48 was visited by her weekly. She said she kept all her documentation on her electronic-pad and when she left, she did not provide copies of the notes to the nursing staff but gave a verbal report to a nursing staff member. She said she had visited the facility the day before and did not know the nurse she verbally reported off to. Hospice Nurse #12 did not know what happened to her verbal report information once the facility nurse left her shift. She said the resident was being well cared for by her and the facility's nursing staff. Hospice Nurse #12 revealed that not all Hospice documentation had been provided to the facility to scan into their electronic medical record. She said it was her expectation that Resident #48's complete Hospice medical records be available to facility staff. An interview on 06/14/24 at 10:20 AM with the facility Nurse Practitioner (NP) revealed that it was her expectation that Hospice provide to the facility all the Hospice documentation timely, which was not being done. The NP stated it was important to her and the attending physician to know what Hospice physicians were ordering and what their nursing staff were doing, so that Hospice and facility staff were communicating well and following the same plan of care, which had not happened in this case. An interview was conducted on 06/13/24 at 10:50 AM with the Administrator. She said it was her expectation that Resident #48's complete Hospice medical records be available to facility staff.	F 849	training for the appropriate staff members. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/27/24

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F 880	Continued From page 322 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 323 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to implement their policy for enhanced barrier precautions and hand hygiene during wound care for 1 of 3 residents (Resident #66) whose wound care was observed. The facility also failed to implement an infection surveillance plan for monitoring and tracking infections in the facility to help prevent the development and transmission of communicable diseases and infections. This deficient practice had the potential to affect 70 of 70 residents in	F 880	The facility failed to implement their policy for enhanced barrier precautions and hand hygiene during wound care for 1 of 3 residents (Resident #66) whose wound care was observed. The facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility to help prevent the development and transmission of communicable diseases	

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F 880	Continued From page 324 the facility. Findings included: 1. Review of the facility Enhanced Barrier Precautions policy documented enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include wound care (any skin opening requiring a dressing). EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE (Personal Protective Equipment) required. PPE is available outside the room. Review of the facility Handwashing/Hand Hygiene policy documented the facility considered hand hygiene the primary means to prevent the spread of healthcare associated infections. Hand hygiene is indicated: immediately before touching a resident, before performing an aseptic task such as placing an indwelling device or handling an invasive medical device, after contact with blood, body fluids or contaminated surfaces, after touching a resident, after touching the resident ' s environment, before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal.	F 880	and infections. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or Designee, will implement and attend an infection control meeting on a weekly basis, as well as assign tasks to appropriate staff members to ensure all aspects of infection prevention and control are being monitored by 8/5/2024. The DON or Designee will educate all staff by 8/5/2024 on the importance of infection prevention and control in all aspects of the long-term care environment. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The DON or Designee will educate the wound care nurse and appropriate nursing staff by 8/5/2024 on utilizing the appropriate PPE and hand hygiene technique while providing residents with wound care, to ensure the risk of infection transmission is minimized. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the DON or Designee will attend an infection control meeting weekly and maintain minutes from each meeting including but not	

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F 880	Continued From page 325 The use of gloves does not replace hand washing/hand hygiene. On 06/14/24 at 10:00 am an observation of the Enhanced Barrier Precautions sign posted on Resident #66's door instructed staff to clean hands before entering and after leaving the room and to wear gloves and a gown for high contact resident care activities including wound care or any skin opening requiring a dressing. A supply of gowns and gloves were located in a bin in the hallway next to the resident's room. An observation of wound care was made on 06/14/24 at 10:12 AM. Present were the Treatment Nurse and the Wound Care Specialist physician. The physician and the nurse donned gloves and gowns prior to entering the room. The physician partially removed the dressing and measured the Stage 4 coccyx pressure ulcer. Both the physician and the nurse removed their gloves and gowns and discarded them in an acceptable receptacle. In the hallway the physician and the nurse used alcohol based hand rub (ABHR). The physician directed the nurse to change the treatment to a new debriding ointment and a border dressing daily. The Treatment Nurse obtained the new ointment from the treatment cart and entered the room without donning a gown. She donned gloves and removed the old dressing and discarded it in an appropriate receptacle. The nurse discarded her gloves and donned new gloves before applying the new treatment. She did not wash her hands or use ABHR after she discarded her gloves or before moving to a clean body site on the same resident. In an interview with the Treatment Nurse after the	F 880	limited to topics discussed, education being provided, and staff members in attendance. Beginning 7/27/2024, the DON or Designee will audit hand hygiene and PPE donning/doffing 3 times per week x 12 weeks to ensure staff are maintaining compliance with EBP regulations. Any lack of competency in the areas of infection prevention and control, to include but is not limited to, PPE donning/doffing and hand hygiene, will result in re-education and additional training for the appropriate staff members. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	

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F 880	Continued From page 326	F 880		

dressing change on 06/14/24 at 10:30 am she stated she changed her gloves between removing the old dressing and applying the new dressing and she thought that was adequate. She stated she did not think she had to wash her hands if she changed her gloves. She acknowledged she had forgotten to wear a gown prior to reentering the room to complete the dressing change and stated she should have put one on.

In an interview with the Infection Preventionist on 06/14/24 at 1:30 PM she stated the Treatment Nurse should have worn a gown during wound care and performed hand hygiene between removing the old dressing and applying the new dressing.

In an interview with the Agency Director of Nursing on 6/14/24 at 4:30 PM she stated she expected staff to wear the appropriate PPE when treating residents on enhanced barrier precautions and perform hand hygiene when indicated.

2. The facility's "Infection Prevention and Control Program" policy dated 4/1/24 stated the Infection Preventionist (IP) was responsible for completing surveillance of healthcare associated infections, tracking outbreaks and monitoring standard and transmission precautions.

During a meeting with the Infection Preventionist (IP) on 6/14/24 at 3:49 pm she stated she started this position on 5/06/24 and was still in orientation. She was unable to provide any documentation of tracking or surveillance of infections, infection risks for the facility from May 2023 through May 2024. The IP provided a binder with monthly computer printouts of infections in the facility from January 2024

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F 880	Continued From page 327 through June 18, 2024. During an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am she stated she began her position as DON on 3/25/24 and was not responsible for infection control. An interview with the Administrator on 6/14/24 at 4:00 pm revealed she had been the Administrator since 2/02/24 and was Statewide Program for Infection and Epidemiology (SPICE) certified. The Administrator stated the IP had not been monitoring or tracking the infections within the facility. She indicated she was helping the IP who was trying to get infection control in order. The Administrator further stated the facility should have been monitoring and tracking infections.	F 880		
F 940 SS=F	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure all staff received training on dementia care, infection control policies and procedures and the elements of the Quality Assurance Performance Improvement (QAPI) program. This practice had the potential to affect	F 940	The facility failed to ensure all staff received training on dementia care, infection control policies and procedures and the elements of the Quality Assurance Performance Improvement (QAPI) program.	7/27/24

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F 940	Continued From page 328 all residents. Findings included: A review of the 2023 and 2024 annual education records from April 2023 to May 2024 provided by the facility revealed no documented evidence that dementia care, infection control training on policies and procedures and QAPI training were conducted for the staff. a. Medication Aide #5's personnel file was reviewed and revealed a date of hire of 11/8/2019. There was no documentation of dementia care, infection control and QAPI training in the personnel file. A phone interview was conducted on 7/1/2024 at 1:23 pm with Medication Aide #5. During the interview, Medication Aide #5 stated she was not able to recall having QAPI training since April 2023 and thought she had received some training on infection control and dementia care in the last year but was unable to recall for certain. b. Nurse Aide (NA) #2's personnel file was reviewed and revealed a date of hire of 8/13/2018. There was documentation NA# 2 had received dementia care training on 12/5/2023, and there was no documentation NA #2 had received infection control training on policies and procedures and QAPI training. A phone interview was conducted on 6/18/2024 at 5:49 pm with NA #2. She stated she felt like training as a whole had been overlooked with the all changes in the administrative team. She indicated she had received training on dementia care and QAPI training since changing roles as	F 940	All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Staff Development Coordinator Registered Nurse (RN), or Designee will review the education that has been provided to all staff from January 2024 until current by 8/5/2024 to ensure ongoing education is being provided. The Licensed Nursing Home Administrator (LNHA) and DON have determined that there has been a trending pattern of failure for the facility not having a full-time Staff Development Coordinator Registered Nurse (RN) for a minimum of one year when investigating this identified issue. However, the LNHA has hired a full-time Staff Development Coordinator RN to ensure compliance. The LNHA, DON, or Designee will educate the Staff Development Coordinator RN by 8/5/2024 on the importance of ongoing education for all staff employed at the facility and will educate on assisting in the formation and completion of an annual educational calendar that will be available for all staff as of 8/5/2024. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. The LNHA, DON, or Designee will	

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F 940	Continued From page 329 the activities director in 2024. She only recalled attending an in-service about not wearing gloves into the hallway as infection control training since April 2023. c. On 6/18/2024 at 06:14 pm in a phone interview with Nurse #8 who had worked at the facility the last two years, she stated she did not know what QAPI was. She said she had not received training while at the facility on QAPI or dementia care and had not received infection control training on policies and procedures since April 2023. d. On 6/19/2024 at 8:31 am in a phone interview with Medication Aide #3, she stated she had worked at the facility since 8/2023. When asked if she had received QAPI training,, Medication Aide #3 stated she did not know what QAPI was. Mediation Aide #3 further stated she had not received infection control training and did not recall receiving dementia care training since 8/2023. e. On 6/1/2024 at 7:56 am in a phone interview with Minimum Data Set (MDS) Nurse #4, she stated There had been no infection control and QAPI training since April 2023 and she was unable to recall receiving dementia care training. On 6/14/2024 at 4:11 pm in a phone interview with the Admissions Coordinator, she stated the facility did not have any evidence that infection control training and QAPI training was provided to all the staff at the facility. She explained when the previous Staff Development Coordinator (SDC) resigned, the SDC's office was cleaned and no one knew what happened to all the training documentation of all the staff at the facility.	F 940	educate the Staff Development Coordinator RN by 8/5/2024 on the importance of ongoing education with all staff to ensure all staff receive training on dementia care, infection control policies and procedures, and the elements of the Quality Assurance Performance Improvement (QAPI) program. After 8/5/2024 newly hired staff will be educated by the DON or Designee during their new hire employee orientation. Beginning 7/27/2024, the LNHA, DON, or Designee will audit 12 employee education records monthly for 12 months to ensure ongoing education is being completed for all staff. Any month identified that education was not completed will result in re-education and additional training for the appropriate staff member. If there are any newly hired staff to begin working at the facility they will also be audited. Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 940	Continued From page 330 In a phone interview with the Director of Nursing (DON) on 6/19/24 at 10:22 am, she stated there was no Staff Development Coordinator (SDC) at the facility when she was hired in March 2024. The DON also stated she was unable to locate any files documenting dementia care, infection control training on policies and procedures and QAPI training to the staff since April 2023. She stated since there was no SDC, she was responsible for documenting the staff's training conducted by different administrative staff members, and stated since March 2024 she had not recorded any training hours and could not recall having training on dementia care, infection control and QAPI training. A phone interview was conducted on 6/19/24 at 12:25 P.M. with the Administrator. The Administrator explained when the SDC resigned two months ago, the SDC role was originally assigned to the new MDS Nurse #2 who was hired in April 2024. She explained MDS Nurse #2 was unable to manage the educational training due to learning the role as an MDS nurse and working on the back log of MDS assessments in the facility. She revealed MDS Nurse #2 had resigned during the state survey. She stated the facility currently did not have a Staff Development Coordinator and the responsibilities of the SDC for ensuring staff received the required annual training of dementia care, QAPI and infection control and documentation of the training fell ultimately to the DON to ensure completion. The Administrator explained there had been a high turnover in the DON position and felt the responsibility of scheduling dementia care, infection control and QAPI training for all the staff and tracking training had been overlooked.	F 940	action.	