STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/08/24 through 9/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2R0311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/08/24 through 9/11/24. Event ID# 2R0311. The following intakes were investigated NC00218619, NC00221486, and NC00221504. 2 of the 6 complaint allegations resulted in deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		10/3/24

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

Electronically Signed | 10/02/2024

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F 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF/ABN) by omitting the estimated cost of services for 2 of 2 residents reviewed for beneficiary notices (Resident #286 and Resident #287).	F 582	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected by the alleged deficient practice.	

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F 582	Continued From page 2 Findings included: a. Resident # 286 was admitted to the facility on 12/27/23. Medicare part A services began on 12/27/23. The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Nurse #2 as issued to Resident # 286's representative via phone on 3/11/24. The notice indicated that Medicare coverage for skilled services was to end 3/13/24. Resident #286 remained in the facility when Medicare coverage ended. Review of Resident #286 's record indicated the SNF/ABN form dated 3/11/24 had no estimated cost of services documented on the form. b. Resident #287 was admitted to the facility on 6/14/24. Medicare part A services began on 6/14/24. The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #287 and on 8/12/24. The notice indicated that Medicare coverage for skilled services was to end on 8/16/24. Resident #287 remained in the facility when Medicare coverage ended. Review of Resident # 287's record indicated the SNF/ABN form dated 8/12/24 had no estimated cost of services documented on the form. During an interview with Nurse #2 on 9/11/24 9:17 am she stated that she completed the SNF ABNs for Resident #286 and Resident #287. She further stated that she was not aware that the estimated	F 582	Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. Example forms were provided to the Interdisciplinary Team Members (Administrator, Social Services Director, Medical Records Director, MDS RN Case-Mix Director, RN Nurse Navigator/ Senior Care Partner, Therapy Outcomes Coordinator, Business Office Manager, and MDS RN Case-Mix Coordinator) for educational purposes by Administrator-in-Training on 9/10/24. Education was provided to the Interdisciplinary Team Members (Administrator, Social Services Director, Medical Records Director, MDS RN Case-Mix Director, RN Nurse Navigator/ Senior Care Partner, Therapy Outcomes Coordinator, Business Office Manager, and MDS RN Case-Mix Coordinator) on proper notification by Administrator-in-Training on 9/11/24. Any IDT Members who have not been educated due to an approved leave of absence, will be educated prior to their next scheduled shift. Education will be provided to all new	

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F 582	Continued From page 3 cost needed to be included on the SNF/ABN form. She concluded she would begin to include the estimated cost in the future. During an interview with the Administrator in Training on 9/10/24 at 3:13 pm, he stated if estimated costs was to be included in the SNF/ABN then it should have been completed for Resident #286 and Resident #287. He stated the Social Worker and Nurse #2 had been responsible to complete the SNF/ABN forms. During an interview with the Administrator on 09/10/24 03:29 pm she stated she had not been aware that the estimated costs had not been completed for Resident #286 and Resident #287. She further indicated that the costs should have been completed.	F 582	Interdisciplinary Team Members (Administrator, Social Services Director, Medical Records Director, MDS RN Case-Mix Director, RN Nurse Navigator/ Senior Care Partner, Therapy Outcomes Coordinator, Administrator-in-Training, Business Office Manager, and MDS RN Case-Mix Coordinator) in orientation moving forward. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Business Office Manager will audit Notices of Medicare Non-Coverage & Skilled Nursing Facility Advance Beneficiary Notices to ensure proper notification: Audits of each notification will be conducted for 2 weeks; Then every other notification for 2 weeks; Then 4 random audits will be conducted for 1 month. Administrator-in-Training/ Business Office Manager to report findings to QAPI Committee for 3 months or until sustained compliance has been achieved. QAPI committee to determine if ongoing monitoring is needed. Date of compliance 10/3/2024	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		10/3/24

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F 641	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code a significant change in status Minimum Data Set (MDS) assessment following hospice election for 1 of 1 resident (Resident #56) reviewed for hospice. The findings included: Resident #56 was readmitted to the facility on 8/15/24 with diagnoses that included acute respiratory failure, acute pneumonitis (pneumonia) and Alzheimer's dementia. A review of Resident #56's hospice election form revealed she was admitted to hospice on 8/19/24. A review of Resident #56's electronic health record revealed a significant change Minimum Data Set (MDS) was completed on 8/19/24. The MDS did not indicate the resident had been admitted to hospice. In an interview with the MDS nurse on 9/11/24 at 8:17 AM She further stated she learned about significant changes in morning meeting every day and she was aware Resident #56 had been admitted to hospice. The MDS nurse revealed the significant change MDS that was completed on 8/19/24 should have indicated the resident was admitted to hospice. She was not sure how it was missed. In an interview with the Administrator on 9/11/24 at 8:39 AM she stated the MDS completed on 8/19/24 should have captured that Resident #56 was admitted to hospice.	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Significant Change Assessment for Resident #56 completed on 8/19/24 was modified on 9/11/24 to reflect Hospice services. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving Hospice services have the potential to be affected. ALL Hospice Residents were reviewed to determine if the significant change assessment reflected the Hospice service in section O0110b on 9/11/24. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. Clinical Reimbursement Coordinator RN educated the MDS RN Case-Mix Director and the MDS RN Case-Mix Coordinator on proper coding of Section O0110b on Significant Change Assessment on 10/2/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 641	Continued From page 5	F 641	The MDS Case-Mix Nurses will audit each other□s Significant Change Assessments related to Hospice weekly for accuracy of coding Hospice services in section O0110b. MDS RN Case-Mix Director will report findings to QAPI monthly for 3 months or until sustained compliance has been achieved. QAPI committee to determine if ongoing monitoring is needed. Date of Compliance 10/3/2024	
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 observation, record review, and resident and staff interviews, the facility failed to provide a safe transfer for 1 of 1 resident (Resident #285) reviewed for supervision to prevent accidents. On 8/26/24 Resident #285 was assessed by Physical Therapist #1 to have required a mechanical lift transfer. The mode of transfer had not changed and on 9/5/24 Nursing Assistant (NA) #1 and NA #2 transferred Resident #285 from the bed to a chair without the use of a mechanical lift.	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The plan of care for Resident #285 was updated to indicate the proper transfer for the resident. Resident #285 discharged on 09/13/24. Address how the facility will identify other	10/3/24

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F 689	Continued From page 6 Findings included: Resident #285 was admitted to the facility on 8/23/24 with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen levels in the body), anxiety, muscle weakness, unsteady on feet, shortness of breath, and pneumonia. The admission Minimum Data Set (MDS) assessment dated 8/30/24 revealed that Resident #285 was moderately cognitively impaired. She was dependent on staff for transfers from bed to chair. She required the use of supplemental oxygen. Review of a care plan for Resident #285 dated 8/23/24 revealed she was at risk for falls related to cardiac dysrhythmia (abnormality of heart rhythm), and generalized weakness. Interventions included assist for toileting and transfers as needed. Review of the physical therapy initial evaluation and plan of treatment for Resident #285 dated 8/26/24 revealed Resident #285's baseline for sitting to standing was "patient unable to stand despite max A +2 [maximum assistance of 2 persons]." The evaluation further revealed Resident #285 was unable to ambulate. In an interview with Physical Therapist (PT) #1 on 9/10/24 at 11:22 am she stated she had evaluated Resident #285 on 8/26/24 and had determined a mechanical lift was the safest mode of transfers because Resident #285 could not stand safely related to weakness and unsteadiness on her feet. She stated a	F 689	residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. Education was provided to NA #1 by the Clinical Competency Coordinator to review the resident□s care profile for proper transfer techniques on 9/24/24. Education was provided to NA #2 by the Clinical Competency Coordinator to review the resident□s care profile for proper transfer techniques on 9/20/24. Lift observations were completed for all current residents by Nursing Managers (Clinical Competency Coordinator, RN Nurse Navigator/ Senior Care Partner, RN Unit Manager, and LPN Unit Coordinator) by 9/19/24. Care plans for all residents were updated to reflect their current lift observation/ transfer status by 9/19/24. All Resident Profiles were updated to reflect their current lift observation/ transfer status by 9/19/24. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. Education will be provided to all direct care staff by the Clinical Competency Coordinator to review the resident□s care profile for proper transfer techniques by date of compliance. All direct care staff not educated by the date of compliance due to an approved leave of absence will	

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F 689	Continued From page 7	F 689		

two-person physical assist without the use of a mechanical lift put Resident #285 at a risk for falls related to poor physical strength. The interview further revealed NA #1 told PT #1 she transferred Resident #285 without the use of a mechanical lift on 9/5/24 and that concerned her because NA #1 should have used a mechanical lift.

In an interview with Resident #285 on 9/11/24 at 9:58 am she stated on 9/4/24 the therapist (not sure which one) told her she wanted Resident #285 out of bed for therapy on 9/5/24 and to let the Nursing Assistants (NAs) know when they came to get her up to use the mechanical lift. Resident #285 stated that on 9/5/24 NA#1 and NA #2 came to assist her out of bed, and she told them to use a mechanical lift for the transfer and NA #1 told her they (NA #1 and NA #2) were sent to get her out of bed and into the chair and that was what they were doing. She stated when NA #1 and NA #2 assisted her to stand up to transfer to the chair she could feel herself falling and staff grabbed her by her underarms and it "hurt like hell" and it scared her because she thought she was going to fall. The interview further revealed that Resident #285 had pneumonia and had difficulty breathing and the exertion from the transfer made her short of breath.

In an interview with NA #1 on 9/10/24 at 11:12 am she stated she transferred Resident #285 from the bed to a chair without the use of a mechanical lift on 9/5/24 because she had not been aware at that time that Resident #285 required a mechanical lift. She stated Resident #285's care card had indicated that she was a two person assist for transfers. She indicated that NA #2 assisted her to transfer Resident #285. She stated Resident #285 held onto a walker during

be educated prior to their next scheduled shift.

Education to be provided to all new direct care staff to review the resident□s care profile for proper transfer techniques in orientation moving forward.
All newly admitted residents will have a lift observation completed to indicate what transfer status is appropriate upon admission, no later than 24-hours after admission.

The therapy department will indicate appropriate transfer technique following the initial assessment (if applicable) and communicate this information to Nursing.
A new communication form will be utilized if changes in transfer status are indicated.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Audits will be conducted by Nurse Managers or designee to ensure proper and appropriate transfers are taking place:
Transfer observation audits will be conducted for 5 days weekly for 4 weeks;
Then 3 days weekly for 4 weeks;
Then weekly for 4 weeks;
Care plan audits will be conducted for 5 days weekly for 4weeks;
Then 3 days weekly for 4 weeks;
Then once weekly for 4 weeks.
Director of Health Services to report

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F 689	Continued From page 8	F 689		

the transfer, became short of breath, could not pivot to turn, and sit in the chair. NA #1 explained she and NA #2 assisted Resident #285 to sit on the side of bed until she could regain her breath and then they continued with the transfer to the wheelchair. NA #1 indicated Resident # 285 did not tell her that she should have used a mechanical lift until after she had been transferred into the chair. She stated on 9/5/24, after the transfer had occurred, Physical Therapist (PT) #1 told her that Resident #285 should have been transferred using a mechanical lift.

During an interview with NA #2 on 9/11/24 at 11:08 am she stated she assisted NA #1 on 9/5/24 to transfer Resident #285 from the bed to a wheelchair. She indicated they did not use a mechanical lift for the transfer because Resident #285's care card indicated she had been a two person assist for transfers and did not indicate a mechanical lift had been required. She stated when she arrived at Resident #285's room on 9/5/24 to assist NA #1 with the transfer that Resident #285 was sitting on the side of the bed with her legs over the edge of the bed and feet on the floor. She stated when they assisted the resident stand up the resident stated, "I can't do it, I can't do it," so they assisted her to sit back down on the bed by holding her under each arm, on each side of the resident. She stated NA #1 told Resident #285 they were going to transfer her to the chair and asked if she was ready and Resident #285 agreed she was. She stated Resident #285 stood up and NA #1 and NA #2 assisted her to pivot to the chair and sat her down. They stated the resident was able to bear weight during the transfer, but they helped her maintain her balance. She stated after Resident

findings to QAPI for 3 months or until sustained compliance has been achieved. QAPI committee to determine if ongoing monitoring is needed.

Date of Compliance 10/3/2024

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#285 was seated in the wheelchair that she was short of breath and that concerned her, so she checked on her frequently afterward until she was no longer short of breath.

In an interview with Certified Occupational Therapy Assistant (COTA) #1 on 9/11/24 at 10:05 am she stated that on 9/4/24 she told Resident #285 to tell the NA staff to use a mechanical lift when they got her up for therapy on 9/5/24. The COTA stated after Resident #285 was out of bed, the resident told her NA #1 and NA#2 had transferred her without the use of a mechanical lift. She stated Resident #285 could not bear weight to stand related to weakness so she should have been transferred with a mechanical lift. She stated Resident #285 had not had a change in her transfer status since she had been admitted. She stated if there had been a change in how Resident #285 transferred a therapist would have communicated that to the nursing staff verbally. The interview revealed there had not been a formal process in place for therapy to communicate modes of transfer to nursing staff.

In a follow-up interview with PT #1 on 9/11/24 at 10:45 am she confirmed she documented in her physical therapy progress notes on 8/26/24 Resident #285 was not safe to bear weight and that she verbally notified the nurse on duty that day. She stated she did not recall which nurse she spoke to.

In a follow-up interview with Nurse #6 on 9/11/24 at 11:51am she stated she worked on 8/26/24 when therapy did the initial evaluation on Resident #285, but she did not recall if a therapist told her to transfer Resident #285 with a mechanical lift. She further indicated therapists

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would tell the NAs how to transfer a resident and the NAs would tell the nurse so the nurse could update the care plan. She stated she was not told how Resident #285 should transfer at any time and had not updated the care plan.

In an interview with the Director of Nursing (DON) on 9/11/24 at 8:21 am she stated if a resident required a mechanical lift for transfers that they should be transferred with a mechanical lift unless therapy changed the mode of transfer. She stated therapy communicated verbally to the nursing staff about how a resident should be transferred.

In a follow up interview with the DON on 09/11/24 at 1:03 pm she stated that on admission a nurse assessed a resident to see how they would transfer until therapy assessed the resident. She stated therapy usually assessed residents the next day after admission and determined how the resident should be transferred and then therapy would tell the nurse. She stated that the safest mode of resident transfers was also discussed in morning meeting with the interdisciplinary team each day. She stated there was not a set system on how to communicate on how to transfer residents and without a system someone could be transferred incorrectly. She explained therapy initially assessed Resident #285 and assessed her mode of transfer to be a mechanical lift. She said the facility needed a process to communicate about transfers after a resident was assessed by therapy. She further indicated when NA #1 and NA #2 noticed Resident #285 became short of breath they should have reported the resident being short of breath to the nurse before they continued with the transfer. She stated when therapy notified Nurse #6 Resident #285 should

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F 689	Continued From page 11 be transferred with the use of a mechanical lift that Nurse #6 should have notified the DON or MDS nurse so they could have updated the care plan. During an interview with the Administrator on 9/11/24 at 1:32 pm she stated Resident #285 had been assessed by nursing when admitted and Resident #285 required two-person assistance to transfer out of bed, and that was put on the care plan. She stated therapy did not always make the determination on how a resident should be transferred.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Physician interview the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41%, for Medication Administration. Both errors were for medications received by Resident #77. Findings included: a. A review of Resident #77's medication orders dated 7/29/24 revealed he was prescribe one 325 mg (milligram) aspirin by mouth once daily. Further review of the resident's orders revealed	F 759	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Nurse Practitioner notified of medication error for Resident #77 on 9/10/24. Resident medication error documentation was completed on 9/10/24. Orders were received to monitor Resident #77 for 24 hours on 9/10/24. No adverse effects noted for Resident #77. Education provided to Nurse #1 on medications not to be crushed by the	10/3/24

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F 759	Continued From page 12 he was to be given medications "whole in puree" (meaning not to crush the medications and to place the medication in a food to help with administration such as applesauce). On 9/10/24 at 8:35 AM Nurse #1 was observed as she prepared and administered four medications to Resident #77. The medications administrated included one enteric coated aspirin 325 mg. All of the resident's medications were crushed and administered to the resident in applesauce. In an interview with Nurse #1 on 9/10/24 at 9:28 AM she stated she had been crushing Resident #77's medications as he had been having trouble swallowing them whole. Nurse #1 revealed she used an enteric coated aspirin instead of a regular aspirin as that was what she had in her cart, and she should have gone to the medication storage room for the correct aspirin. b. A review of Resident #77's medication orders dated 7/29/24 revealed he was prescribed one Metoprolol Succinate extended release tablet 50 mg by mouth once daily. Further review of the resident's orders revealed he was to be given medications "whole in puree" (meaning not to crush the medications and to place the medication in a food to help with administration such as applesauce). On 9/10/24 at 8:35 AM Nurse #1 was observed as she prepared and administered four medications to Resident #77. The medications administrated included one Metoprolol Succinate extended release tablet 50 mg to be given by mouth. All of the resident's medications were crushed and administered to the resident in	F 759	Clinical Competency Coordinator and the Pharmacy Consultant on 9/12/24. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. All licensed nursing staff were educated by the Clinical Competency Coordination on medications not to be crushed due to possible adverse effects. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. All licensed nursing staff were educated by the Clinical Competency Coordination on medications not to be crushed due to possible adverse effects. Any licensed nurses who have not been educated due to an approved leave of absence will be educated prior to their next scheduled shift. Education regarding medications not to be crushed will be completed with all new licensed nurses in orientation moving forward. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Nurse Managers or designee will audit the accuracy of medication administration regarding medications not to be crushed:	

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F 759	Continued From page 13 applesauce. In an interview with Nurse #1 on 9/10/24 at 9:28 AM she stated she had been crushing Resident #77's medications as he had been having trouble swallowing them whole. She further stated she knew she should not have crushed Metoprolol Succinate extended release because that changes it from a long acting to a short acting medication. She further revealed she should have contacted the Physician or Nurse Practitioner to change his order from taking medication whole to crushed. An interview with the Pharmacist on 9/10/24 at 2:03 PM revealed Metoprolol Succinate extended release should not be crushed as it changes it to immediate release and can lower the residents blood pressure and/or pulse. He stated enteric coated aspirin should not be crushed as the enteric coating protects the stomach lining. He further revealed if a residents orders changed from taking medications whole to crushed, he would recommend an equivalent medication that can be crushed. He stated the pharmacy did not receive a request for recommendations for crushable medications for Resident #77. An interview with the Director of Nursing (DON) on 9/10/24 at 9:22 AM revealed Metoprolol Succinate extended release should not have been crushed as it changes it from a long-acting medication to a short acting one that could cause a drop in blood pressure or pulse for the resident. The DON stated the nurse should have known not to crush it. She further stated she expected nursing to follow the orders in the electronic medication administration record including how residents took their medications. If a resident	F 759	Medication pass audits will be conducted for 5 days a week for 4 weeks; Then 3 days a week for 4 weeks; Then once weekly for 4 weeks. Director of Health Services to report findings to QAPI monthly for 3 months or until sustained compliance has been achieved. QAPI committee to determine if ongoing monitoring is needed. Date of Compliance 10/3/2024	

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F 759	Continued From page 14 needed a change from taking medications whole, to taking them crushed, nursing would contact the Physician or Nurse Practitioner for that order and any changes from medications that could not be crushed to an equivalent medication that could be crushed. In an interview with the Physician on 9/11/24 at 8:02 AM he stated Metoprolol Succinate extended release should not be crushed as it could cause the resident's blood pressure and/or pulse to drop. He further stated Resident #77 did not have an order for enteric coated aspirin and enteric coated aspirin should not be crushed if it was given. The Physician revealed Resident #77 did not have an order for medications to be crushed but had an order for them to given whole in puree.	F 759		
F 760 SS=G	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 staff, resident, family member, Pharmacist, Psychiatric Nurse Practitioner (NP), and Nurse Practitioner (NP) interviews the facility failed to administer prescribed medications for 1 of 1 resident (Resident # 45) reviewed for significant medication errors. Resident #45 was not administered 10 consecutive doses of lorazepam (anti-anxiety medication) during the time period of 7/29/24 through 8/01/24 when the order was erroneously discontinued on the Medication Administration Record (MAR) by the Director of	F 760	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Nurse Practitioner was notified of the medication error on 8/1/24. Resident medication error documentation will be completed for Resident #45 by the date of compliance. The order for Lorazepam was reinstated on 8/1/2024.	10/3/24

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F 760	Continued From page 15 Nursing (DON) which caused Resident #45 to experience increased anxiety. Resident #45 was assessed by the NP on 8/01/24 due to severe anxiety and noted the resident was crying and asking for his medication. Findings included: Resident #45 was admitted to the facility on 1/8/24 with a diagnosis that hypertension (high blood pressure), anxiety disorder, and asthma. Review of Physician orders dated 6/1/24 indicated Resident #45 had been prescribed lorazepam, 1 mg (milligram) tablet, take one tablet 4 times a day for anxiety disorder. Review of the Physician orders dated indicated Resident #45 had been prescribed lorazepam 1 mg per 1ml (milliliter) to be given orally in a syringe for anxiety as needed (PRN). Review of the Quarterly Minimum Data Set (MDS) dated 7/2/24 revealed Resident #45 was severely cognitively impaired and was coded to receive an anxiolytic (medication to treat anxiety). Review of the 2024 July and August Medication Administration Record (MAR) revealed Resident #45 was not administered a total of 10 doses of his prescribed lorazepam (a medication to treat anxiety) on 7/29/24 (2 doses), 7/30/24 (4 doses), 7/31/24 (4 doses), and 8/1/24 (2 doses). This was evidenced by the absence of nursing initials on the MAR for the dates of the missed doses. The order on the MAR had a discontinue date of 7/29/24. Additionally, the MAR revealed Resident #45 was not administered any doses of PRN lorazepam.	F 760	Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. All current residents with orders for Lorazepam will be audited for the past 3 months to ensure that their orders are accurate by the date of compliance. Any deficiencies noted will be corrected. Address what measures will be put into place or systematic changes made to ensure that the deficient HS Senior Nurse Consultant educated Director of Health Services on the Pharmacy Fill Review Policy on 9/26/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted by the Senior Nurse Consultant on the Pharmacy Fill Review: Weekly audits for 8 weeks; Then once monthly for 3 months. Director of Health Services to report findings to QAPI monthly for 3 months or until sustained compliance has been achieved. QAPI Committee to determine if ongoing monitoring is needed. Date of Compliance 10/3/2024	

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Review of the Controlled Drug Record for Resident #45's lorazepam 1 mg tablet revealed that Nurse #7 signed on 7/29/24 at 8 pm and on 7/30/24 at 9 pm that 2 doses of lorazepam had been administered. These doses were not signed off as administered on the MAR.

During an interview with Nurse #7 on 09/10/24 at 11:00 am he stated that he did not recall if he had administered lorazepam 1 mg tablet to Resident #45 on 7/29/24 or 7/30/24. He further indicated that if he did not have an order for it, he would not have administered it.

In an interview with Nurse # 5 on 9/10/24 at 2:47 pm she stated she had worked 7/31/24 and saw that Resident #45's lorazepam had been discontinued so she did not administer it because the order needed to be renewed. She stated she put in a request for the NP to see him and renew the lorazepam. She stated that she did not administer the PRN lorazepam on 7/31/24 because he had not been anxious. The interview further revealed that one day (date unknown) during the first part of July the family had asked that Resident #45's lorazepam dose be held so he would not be drowsy when the family visited that day, but they had not asked that it be stopped.

During an interview with Nurse #4 on 9/10/24 at 3:53 pm she stated that when the pharmacy refill review request (a record of orders that are scheduled to be refilled) came electronically on 7/29/24 that it got "messed up by someone" (she did not know who), and Resident #45's scheduled lorazepam had been discontinued and had to be restarted. She stated when it had been brought to

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her attention by nursing staff that his lorazepam had been discontinued, she notified the NP to get it reordered on 8/1/24. She recalled that a hydroxyzine order had been received from the NP to be given until the scheduled lorazepam had been reordered. She further indicated that no one had reported to her that he had been overly anxious, and if he had been he had an order for PRN lorazepam that he could have received.

In an interview with Resident #45 on 9/10/24 at 8:19 am he stated he recalled that he had not received his prescribed anxiety medication for several days one time but could not recall the name of the medication or the exact dates. He stated he went "bezerk" and that was what happened when staff forgot to give him his anxiety medication. He further clarified that it made him feel bad overall but could not further describe how he felt. He stated that the nurse (he could not recall her name) gave him "some sort of a concoction" and that made him feel better, and he had felt fine since.

Review of a NP progress note written by the NP dated 8/1/24 read in part, "I was called to see [Resident #45] due to his severe anxiety. [Resident #45] was crying and asking for his medications. [Resident #45] was given hydroxyzine [a non-narcotic medication that helped to reduce anxiety] 50 mg by mouth stat [immediately]. Apparently, his Ativan [lorazepam] has been abruptly discontinued. Initially I was told it was by his [family member's] desire but on further investigation it was discontinued from the MAR. The [lorazepam] was resumed as ordered."

Review of Physician orders dated 8/1/24 indicated that Resident #45 was prescribed

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hydroxyzine 25 mg tablets, give 2 tablets 50 mg stat one time dose for anxiety. The order had a start and stop date of 8/1/24.

A review of the August MAR revealed that lorazepam, 1 mg to be administered four times a day was reordered and transcribed to the MAR for Resident #45 on 8/1/24, and it was administered as ordered.

An interview with Nurse #3 on 9/11/24 at 8:44 am she stated on 8/1/24 she was assigned to administer medications to Resident #45 and administered a dose of hydroxyzine 50 mg as a stat (immediately) as one time dose for anxiety, but could not remember what time she had given it. She stated Resident #45 had increased anxiety on 8/1/24 and she could not remember if he had been crying or what his behaviors had been on 8/1/24 because he often became anxious. She stated she did not recall if he had lorazepam ordered at that time or if she had administered it. She further indicated that she did not routinely work with Resident #45, so it was difficult to recall the exact details of the day.

In an interview with the NP on 9/10/24 at 9:18 am she stated that Resident #45 sometimes became groggy when he took the lorazepam, and she was told by nursing staff that his family member wanted the lorazepam stopped. She further stated a nurse told her the facility had not renewed the lorazepam because Resident #45's family member had not wanted it renewed. She could not recall the name of the nurse. She stated that lorazepam should not have been abruptly stopped because it could have caused a rebound of anxiety. She further indicated that she had ordered hydroxyzine when she learned the

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lorazepam had been discontinued and reordered the lorazepam.

An interview with the Director of Nursing (DON) on 9/11/24 at 8:04 am revealed that she had erroneously discontinued Resident #45's lorazepam on 7/29/24. She stated that the pharmacy sent an alert that Resident #45 had 2 lorazepam orders, so she had reviewed the orders and had not realized that one of the lorazepam orders had been for PRN lorazepam 1 mg per 1 milliliter (ml) to be given orally in a syringe, and she thought it was a duplicate lorazepam order and discontinued the scheduled lorazepam 1 mg to be given 4 times a day. She stated that on 8/1/24 a nurse (she did not recall the name) notified her that the order for Resident #45's scheduled lorazepam had been discontinued so she asked the Nurse #4 to notify the NP to reorder the lorazepam and she did. The interview further revealed that Resident #45's family had not contacted her to ask that the lorazepam order be discontinued. She further indicated that the lorazepam should not have been discontinued and Resident #45 should have received scheduled lorazepam on 7/29/24, 7/30/24, 7/31/24, and 8/1/24. She stated the lorazepam 1 mg tablets had been available for administration and had not yet been returned to the pharmacy.

During an interview with Resident #45's family member on 9/11/24 at 9:26 am she stated that Nurse # 4 notified her on 8/1/24 that Resident #45 had become combative, yelled, cursed, and they could not get him to calm down and the doctor ordered a medication to calm him down. She stated she did not know what medication had been ordered. The interview further revealed that

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she had not asked the facility to stop his lorazepam and had only asked the facility to hold one dose around the 7/19/24 so family could visit. She stated that when he did not get his scheduled lorazepam that he became combative and upset.

In an interview with the Psychiatric Nurse Practitioner on 9/10/24 at 12:09 pm she stated Resident #45 had been ordered lorazepam to be given on a routine scheduled basis, as well as lorazepam to be given on an as needed (PRN) basis, so he should not have missed any doses of his lorazepam. She further stated she would have expected that the nurses would have given him the PRN lorazepam if they did not have an order for the scheduled lorazepam. She stated that she did not discontinue the scheduled lorazepam, and was unaware it had been discontinued. She stated lorazepam should not have been stopped abruptly as it could have caused increased agitation for the resident.

In an interview with the Pharmacist on 9/10/24 at 02:10 pm he stated that according to his records the order for lorazepam for Resident #45 had been discontinued by the Director of Nursing (DON) on 7/29/24 and it had been reordered on 8/1/24 by the Nurse Practitioner. He further stated that lorazepam should not have been stopped abruptly and should have been titrated (dose lowered by over a period of several days) to a lower dose and then tapered off before it had been stopped. He stated if it had been abruptly stopped that Resident #45 could have experienced irritability, tremors, sweating, panic attacks, headaches, and worsened anxiety.

In an interview with the Administrator on 9/11/24 at 1:25 pm she stated Resident #45 should have

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F 760	Continued From page 21 received his medications as ordered and not missed doses. She stated that nurses administered medication according to the order on the MAR. She further indicated the error occurred because of the way the medication re-order system was set up and that the lorazepam had been restarted for Resident #45 when they became aware it had been stopped.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		10/3/24

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F 761	Continued From page 22 Based on observations and staff interviews the facility failed to keep medications in a locked treatment cart for 1 of 2 treatment carts observed (Treatment Cart #1). Findings included: During observation on 9/9/24 at 3:33 PM Treatment Cart #1 was observed to be unlocked and unattended on the 100 hall with the locking mechanism popped out in the unlocked position. At 3:33 PM a resident rolled to the cart and stopped approximately 5 feet from it and remained there through the observation. At 3:34 PM a nurse aide pushing a resident in a wheelchair and a restorative aide walked past the unlocked treatment cart. At 3:35 PM a visitor walked past the unlocked treatment cart. At 3:35 PM the MDS Nurse walked to the unlocked treatment cart, noted it was unlocked, and locked Treatment Cart #1. During an interview on 9/9/24 at 3:36 PM the MDS Nurse stated Treatment Cart #1 was being used by Treatment Nurse #1. She stated it should be locked when unattended and was why she locked it when she saw it was not locked as she was passing by. During an interview on 9/9/24 at 3:40 PM Treatment Nurse #1 stated treatment carts were to be locked when unattended. He stated he did not have a reason the treatment cart was left unlocked. During observation on 9/9/24 at 3:44 PM with Treatment Nurse #1, the treatment cart was observed to contain calmoseptine ointment, triamcinolone acetonide cream 0.1%,	F 761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected by the alleged deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. Education was provided to Treatment Nurse #1 by the Clinical Competency Coordinator on properly securing the treatment cart on 9/12/24. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. Education will be provided to all licensed nurses on securing medication and treatment carts by the Clinical Competency Coordinator by the date of compliance. Any licensed nurses who have not been educated due to an approved leave of absence will be educated prior to their next scheduled shift. Education to be provided to all new nurses on properly securing the medication and treatment carts in orientation moving forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 09/11/2024

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F 761	Continued From page 23 Mometasone Furoate Cream 0.1%, nystatin ointment 100,00 units per gram, nystatin topical powder 100,000 units per gram, sodium hypochlorite solution 0.50%, hydrogen peroxide, wound cleanser, triamcinolone cream 0.1%, corn starch powder, wound solution, ketoconazole shampoo 2%, and 1.5% dimethicone. During an interview on 9/10/24 at 7:54 AM the Director of Nursing stated treatment carts were to be locked when unattended.	F 761	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted by Nurse Managers or designee to ensure medication / treatment carts are secured: Audits to be conducted 5 days weekly for 4 weeks; Then 3 days weekly for 2 weeks; Then once weekly for 4 weeks; Director of Health Services to report findings to QAPI monthly for 3 months or until sustained compliance has been achieved. QAPI Committee to determine if ongoing monitoring is needed. Date of compliance 10/3/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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,	F 880		10/3/24

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F 880	Continued From page 24	F 880		

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:
(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

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F 880	Continued From page 25 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 observation, record review and staff interview the facility failed to implement their policies and procedures for hand hygiene when Nurse #1 failed to perform hand hygiene before donning gloves and after glove removal for 1 of 2 Nurses observed for hand hygiene during medication administration. Findings included: A review of the facility policy titled Medication Administration: Hand Hygiene dated 10/17/2023 stated in part: During medication administration ...use hand hygiene before and after glove removal. The policy definition of hand hygiene stated: The cleansing of hands by using the organization-approved, alcohol-based hand sanitizer or by washing hands with soap and water. An observation was started on 9/10/24 at 8:15 AM of Nurse #1 administering medications to a resident. She performed hand hygiene with alcohol based sanitizer upon leaving the room. During the second observation at 8:30 AM on 9/10/24, after collecting the needed supplies and medications, Nurse #1 was accompanied to the	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected by the alleged deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. Education will be provided to Nurse #1 on proper hand hygiene by the RN Infection Preventionist or designee by date of compliance. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. Education will be provided to all licensed nurses on proper hand hygiene and a hand hygiene competency skill check will	

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F 880	Continued From page 26 resident's room. Once in the room, Nurse #1 set down the glucose monitoring supplies, a cup of water and the medication cup, put on disposable gloves and proceeded with handing Resident #18 the medication cup and water. Nurse #1 was observed administering medications and performing a blood glucose test on Resident #18. Nurse #1 did not perform hand hygiene before putting on gloves. After Resident #18 took his medication, Nurse #1 completed the blood glucose test, removed her gloves and threw them away before proceeding to the medication cart in the hallway. Nurse #1 did not perform hand hygiene after removing her gloves. In an interview with Nurse #1 on 9/10/24 at 12:00 PM she stated she was aware she should have performed hand hygiene before donning gloves to perform the blood glucose test and after removing her gloves after the test. She further revealed she did not perform hand hygiene because she was nervous and had a bad headache. An interview with the Infection Preventionist on 9/10/24 at 12:06 PM revealed Nurse #1 should have washed her hands after removing gloves when done with the blood glucose test. In an interview with the Director of Nursing (DON) on 9/10/24 at 10:21 AM she stated Nurses are trained in infection control upon hire and at least yearly. She further stated Nurse #1 should have washed her hands and donned gloves before performing the blood glucose test and should have washed her hands after removing her gloves when done with the test.	F 880	be completed by the RN Infection Preventionist or designee by the date of compliance. Education to be provided to all new licensed nurses in orientation moving forward on proper hand hygiene. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted by Nurse Managers or designee to ensure proper hand hygiene technique is followed per policy: Hand hygiene audits will be conducted 3 times daily for 5 days a week for 4 weeks; Then 2 times daily for 3 days a week for 4 weeks; Then once weekly for 4 weeks. Director of Health Services to report findings to QAPI monthly for 3 months or until sustained compliance has been achieved. QAPI Committee to determine if ongoing monitoring is needed. Date of Compliance 10/3/2024	