STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTH AND REHABILITATION CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 10/28/24 through 10/30/24. Event ID 3OKN11. The following intakes were investigated: NC00222992, NC00223058, NC00223015, NC00221446, NC00222287, NC00223252, NC00222156, NC00223310, and NC00223350. 1 of 14 allegations resulted in a deficiency.	F 000		
F 600 SS=D	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 staff and residents, the facility failed to protect the resident's right to be free from physical abuse by a resident for one of three residents (Resident (R) 1) reviewed for abuse. R2, who had severe cognitive impairment, hit R1 in the back of the	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s	11/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/12/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 head with his fist after a dispute over a TV channel. Findings included: Review of R1's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R1 admitted to the facility on 07/12/24 with diagnoses including other speech and language deficit, abnormalities of gait and balance, and intellectual disabilities. Review of R1's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/09/24, revealed a "Brief Interview for Mental Status (BIMS)" could not be completed due to the resident rarely being understood. Review of R2's "Admission Record," located in the "Profile" tab of the EMR, revealed R2 admitted to the facility on 07/01/20 with diagnoses including major depressive disorder and cognitive communication deficit. Review of R2's quarterly "MDS," with an ARD of 10/01/24, revealed a "BIMS" score of five out of 15, which indicated severe cognitive impairment. Review of R2's "Care Plan," located under the "Care Plan" tab of the EMR and dated 07/31/24, revealed the resident did not have a care plan related to aggressive behaviors. Review of "Nurse's Notes," located in the EMR under the "Notes" tab, revealed no documentation related to the incident that occurred on 10/12/24 between R2 and R1. Review of an "Investigation Summary and	F 600	allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 600 1. The facility failed to implement effective measures and interventions to protect resident # 2 from resident #1 hitting resident #2. 2. Current residents are at risk for deficient practice The last seven days of progress notes of current residents were reviewed for aggressive behaviors to ensure interventions are in place on 11/11/2024. 3. Administrator or designee will provide training to current staff on dementia care and managing aggressive behaviors. This education includes examples of aggressive behaviors and ways to prevent and manage aggressive behaviors. Current staff also received education by administrator or designee that when a resident exhibits aggressive behavior the staff will stay with the resident to provide one on one supervision and immediately notify management. This was completed on 11/15/2024 Agency staff will be educated prior to the start of their shift by Administrator or Staff Development Coordinator Any staff who did not receive the education by the compliance date was removed from the schedule until completed All new staff will receive education during the orientation process. 4. DON or designee will review current resident progress notes for aggressive	

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F 600	Continued From page 2 Conclusion," completed by the Administrator and dated 10/15/24, revealed R2 admitted to hitting R1 on the head and calling him a derogatory name on 10/12/24 due to R1 changing the TV channel. R1 was assessed to have no injuries; however, there was no documentation of a skin assessment. The investigation concluded the incident did occur; however, the facility did not substantiate abuse due to R2's mental status. During an interview on 10/28/24 at 3:20 PM, R1 was asked what happened between him and R2 on 10/12/24. R1 pointed outside, said "he (meaning R2) was there, always walked," and then R1 took a closed fist and put it up against the side of his head. R1 was unable to provide any specifics, but said they know what it is. He said it's the next room, the tv right there, and R1 pointed to the TV room. He said he sees him, referring to R2, walking in hallway, said he was a nice fellow, and this was the first time this had happened. During an interview on 10/29/24 at 1:20 PM, R2 said that on 10/12/24, a male came into the dining room while he was in there watching tv and went over to the TV to change the channel. He said he told the man he was watching TV. R2 stated he then got up out of his wheelchair and punched the man in the head. R2 said R1 started screaming, and R2 told him to leave "the [f****ing] channel alone," and then the nurses came into the TV room and told R1 to leave. R2 stated the police came and spoke with him but did not write him any tickets and left. During an interview on 10/29/24 at 3:49 PM, Certified Nurse Aide (CNA) 5 stated on the evening of 10/12/24, after she started her 11 PM	F 600	behaviors and ensure interventions are in place daily Monday- Friday x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. 5. The administrator will report the results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes. 6. Date of Completion 11/16/2024	

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F 600	Continued From page 3 shift, she did an initial check to see which residents were still awake. She stated sometime between 1 AM and 3 AM, she observed R1 and R2 in the TV room and R1 stepped out of the room. CNA5 stated when R1 returned to the TV, he noticed that R2 had changed the channel, and they started arguing. She said she did not actually see R2 hit R1, but she reported it to Licensed Practical Nurse (LPN) 3 who told R1 to go back to his room. CNA5 stated this was the first time she was aware of an incident between these two residents. During an interview on 10/30/24 at 2:50 PM, the Administrator stated the incident was reported to her at 7:15 AM on 10/12/24, and that R2 had admitted to hitting R1 with his closed fist. The Administrator stated she did not substantiate the abuse allegation due to the resident's mental capacity.	F 600		
F 609 SS=D	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	F 609		11/16/24

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F 609	Continued From page 4	F 609		

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 interview, the facility failed to report an incident of resident-to-resident abuse immediately to the Administrator and within two hours to the state survey agency for one of three residents (Resident (R) 1) reviewed for abuse. R2, who was severely cognitively impaired, hit R1 on the back of the head with his fist after a dispute over a TV channel. The incident was not reported to the state survey agency for more than 4 hours.
Findings included:

Review of the facility's policy titled, "Abuse/Neglect/Misappropriation," dated 01/23/20, revealed, ". . . All employees are responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation and/or mistreatment of a patient

F609
1. Facility failed to report abuse of Resident # 1 within 2 hours of the action.

2. Current residents are at risk.
3. The Regional Director of Clinical Services conducted education with the Administrator regarding prompt reporting of any type of resident abuse and providing a safe environment¿for all residents. Education also included that any allegation of abuse would need to be reported to the state agency within 2 hours of receiving the allegation.
Education provided to administrator on 11/15/2024

Current staff received education included what to do if abuse is suspected, who to notify for an abuse allegation, timely reporting of abuse concerns, and protecting residents from abuse with immediate action. Education included that any allegation that involved abuse must

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Continued From page 5

as well as any reasonable suspicion of a crime against a patient . . . The Administrator will provide to the State Agency an initial report for occurrences of alleged or reasonably suspected abuse, neglect, exploitation, mistreatment, or crime against a patient of the Center. immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury . . ."

Review of R1's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R1 admitted to the facility on 07/12/24 with diagnoses including other speech and language deficit, abnormalities of gait and balance, and intellectual disabilities.

Review of R1's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/09/24, revealed a "BIMS" could not be completed due to the resident rarely being understood.

Review of R2's "Admission Record," located in the "Profile" tab of the EMR, revealed R2 admitted to the facility on 07/01/20 with diagnoses including major depressive disorder, and cognitive communication deficit.

Review of R2's quarterly "MDS," with an ARD of

F 609

be reported to the state agency within 2 hours of receiving the allegation.
Education provided by Staff Development Coordinator on Abuse/Neglect/Misappropriation/Crimes and initial reporting guidelines. Education provided on 11/15/2024
Agency Staff will be educated by Staff Development Coordinator or designee prior to the beginning of their shift

Any staff member not receiving education will not be allowed to work until education received.

Any new employees will receive education in the orientation process by Staff Development coordinator or designee.
Any new administrators will be educated by the Regional VP or Regional Director of Clinical during the orientation process
4. ¿Regional Vice President or designee will audit 5¿abuse reports for timely reporting within 2 hours of receiving allegation if available/warranted weekly x 4 weeks, then 5 abuse reports if available/ warranted biweekly x 4weeks, then 5 abuse reports if available/ warranted monthly x 1 month.¿
5. The administrator will report the results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes.

6. Date of Completion 11/16/2024

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10/01/24, revealed a "BIMS" score of five out of 15, which indicated severe cognitive impairment.

Review of R2's Care Plan," located under the "Care Plan" tab of the EMR and dated 07/31/24, revealed no care plan related to aggressive behaviors.

During an interview on 10/29/24 at 3:49 PM, Certified Nurse Aide (CNA)5 stated on the evening of 10/12/24, after she started her 11 PM shift, she did an initial check to see which residents were still awake. She stated sometime between 1 AM and 3 AM, she observed R1 and R2 were in the TV room, and R1 stepped out of the room. CNA5 stated when R1 returned to the TV, he noticed that R2 had changed the channel, and they started arguing. She said she did not actually see R2 hit R1, but she reported it to Licensed Practical Nurse (LPN) 3 who told R1 to go back to his room. CNA5 stated it was reported to the unit manager (UM)1 around 7 AM after she arrived.

It was reported to the surveyor that LPN3 had walked out of the facility during a shift; therefore, the LPN could not be interviewed.

During an interview on 10/29/24 at 2:40 PM, UM1 said she came in on the morning of 10/12/24 around 7 AM, and CNA5 told her there was an incident between the two residents in the dining room/tv room. She said CNA5 said there were some words exchanged and one hit the other. UM1 stated she could not remember who hit who because it had been a few weeks. UM1 said she was unsure if she was the first person that staff reported it to, and she thought it may have been reported to the third shift nurses. She stated she

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F 609	Continued From page 7 thought she was the first person in management the incident was reported to. She said she did not ask CNA5 what time it happened, but she said the night shift nurses did not call her to report it to her, and when she called the Administrator, she became aware that she was the first staff to report it. She said any allegations of abuse should be reported immediately to a supervisor. During an interview on 10/30/24 at 2:30 PM, the Director of Nursing (DON) said the incident between R1 and R2 should have been reported immediately to a supervisor so that the incident could be reported to the state survey agency within two hours. During an interview on 10/30/24 at 2:50 PM, the Administrator stated she thought the incident occurred at 7:00 am when it was first reported to her. She said she was unaware it had occurred earlier during the night shift. She said staff should have reported it to her immediately so that it could have been reported to the state survey agency within two hours. Review of an "Investigation Summary and Conclusion," provided by the facility and dated 10/12/24, revealed the Administrator became aware that R2 hit R1 on the head and called him a derogatory name due to R1 changing the TV channel at 7:15 AM on 10/12/24. Review of the facsimile (fax) report of the incident to the state survey agency revealed it was reported at 7:22 AM on 10/12/24. This was more than four hours after the incident occurred.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		11/16/24

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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§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 interview, the facility failed to thoroughly investigate an incident of resident-to-resident abuse for one of three residents (Resident (R) 1) reviewed for abuse. R2, who was severely cognitively impaired, hit R1 on the back of the head with his fist after a dispute over a TV channel. This lack of investigation had the potential to lead to continued episodes of physical abuse.

Findings included:

Review of the facilities policy titled "Abuse/Neglect/Misappropriation" dated 01/23/20 revealed, all reported incidents of abuse, neglect and/or exploitation or any suspicion of death related to such matters that are reported to the Healthcare Administration will be thoroughly investigated, and immediately reported as

F 610

F610
1. The facility failed to complete a thorough investigation for the incident of resident-to-resident abuse.
2. Current residents are at risk
3. The Administrator and Director of Nursing were educated on documentation of incident and when to complete the documentation in the progress notes and how to proceed with an investigation by getting statements, doing skin observations, resident and employee interviews, etc, in order to determine root cause of the incident. Education was completed by Regional Director of Clinical Services on 11/15/2024. The administrator and the Director of Nursing will complete all investigations.
Any new Administrator or Director of

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required.

Review of R1's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R1 admitted to the facility on 07/12/24 with diagnoses including other speech and language deficit, abnormalities of gait and balance, and intellectual disabilities.

Review of R1's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/09/24, revealed a "Brief Interview for Mental Status (BIMS)" could not be completed due to the resident rarely being understood.

Review of R2's "Admission Record," located in the "Profile" tab of the EMR, revealed R2 admitted to the facility on 07/01/20 with diagnoses including major depressive disorder, and cognitive communication deficit.

Review of R2's quarterly "MDS," with an ARD of 10/01/24, revealed a "BIMS" score of five out of 15, which indicated severe cognitive impairment.

Review of R2's "Care Plan," located under the "Care Plan" tab of the EMR and dated 07/31/24, revealed the resident did not have a care plan related to aggressive behaviors.

Review of an "Investigation Summary and Conclusion," provided by the facility and dated 10/15/24, revealed R2 admitted to hitting R1 on the head and calling him a derogatory name due to R1 changing the TV channel. Further review revealed there was a summary of the findings, but there were no staff statements, skin assessments, or interviews with other residents related to the allegations.

Nursing will be educated during the orientation process.

4. Regional VP or Regional Director of Clinical Services will review all facility reported incidents as available weekly. This will be done for a period of 12 weeks.

5. The administrator will report the results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes.

6. Date of Completion 11/16/2024

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During an interview on 10/28/24 at 3:20 PM R1 was asked what happened between him and R2. R1 pointed outside, said "he was there, always walked," and then R1 took a closed fist and put it up against the side of his head. R1 was unable to provide any specifics. He said it's the next room, the tv right there, and R1 pointed to the TV room. He said he sees him, referring to R2, walking in the hallway, said he was a nice fellow, and this was the first time this had happened.

During an interview on 10/29/24 at 1:20 PM, R2 said a male came into the dining room while he was in there watching tv and went over to the TV to change the channel. He said he told the man he was watching TV. R2 then stated he got up out of his wheelchair and punched the man in the head. R2 said R1 started screaming, and R2 told him to leave "the [f***king] channel alone," and then the nurses came into the TV and told R1 to leave. R2 stated the police came and spoke with him but did not write him any tickets and left.

During an interview on 10/30/24 at 1:46 PM the Social Services Director stated she did have a form with questions to ask residents specifically after an incident occurred. She said she did not interview anyone in relation to the incident between R1 and R2 but did not state why. She stated the Administrator usually kept them out of the loop, and she would only do interviews when she was told to, but she was not asked to do any interviews for that investigation.

During an interview on 10/30/24 at 2:30 PM, the Director of Nursing (DON) said there should have been documented interviews with staff and residents.

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LENOIR HEALTH AND REHABILITATION CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

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F 610	Continued From page 11 During an interview on 10/30/24 at 2:50 PM, the Administrator said she verbally interviewed staff, but she did not document those or any resident interviews. She said she looked at R1, but she did not document that a skin assessment was completed. She said it has been a lot for her with all the staff changes.	F 610		
F 657 SS=D	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 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.	F 657		11/16/24

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F 657	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review the facility failed to update care plans to reflect aggressive behaviors and identify interventions related to aggressive behaviors for one of three residents (Resident (R) 2) reviewed for abuse. Findings included: Review of R2's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 10/01/24, revealed a "Brief Interview for Mental Status (BIMS)" score of five out of 15, which indicated severe cognitive impairment. The MDS recorded no behaviors for the resident. Review of R2's "Care Plan," located under the "Care Plan" tab of the EMR and dated 07/31/24, revealed the resident did not have a care plan related to aggressive behaviors. Review of an "Investigation Summary and Conclusion," provided by the facility and dated 10/15/24, revealed R2 admitted to hitting R1 on the head and calling him a derogatory name due to R1 changing the TV channel. During an interview on 10/30/24 at 12:00 PM, the MDS Coordinator (MDSC) said every morning at the start of her shift, she reviewed nursing notes and order summaries and would revise the care plan at that time after she identified any changes. She said other than morning meetings, if there was not a progress note or new order, she would not know if there was a change. She said a resident who had been aggressive and hit another resident should have a care plan with interventions in place to address that. She said	F 657	F657 1. R2 comprehensive care plans has been updated / revised to reflect their current status. 2. Current residents are at risk. Current resident□s care plans will be audited for accuracy in relation to care plans to triggered/documented Behaviors 3. Behaviors including all new behaviors of residents will be discussed in the morning clinical meetings. Care plan team was educated by Regional Director of Clinical Reimbursement regarding the need for updating and completion of comprehensive care plans to reflect the status of current resident behaviors. Education was provided on 11/15/2024 Any new care plan team members will be educated by Regional Director of Clinical Reimbursement or designee during the orientation process. 4. Regional Director of Clinical Reimbursement or Designee will audit 5 Residents for behavior care plan accuracy weekly for 4 weeks, biweekly for 4 weeks, and then weekly for 1 month. 5. The care plan coordinator will report the results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes. 6. Date of Completion 11/16/2024	

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F 657	Continued From page 13 she was on vacation at the time the incident occurred, and there was no one to update care plans while she was gone. She stated when she returned she was brought up to speed as best as possible, but there were things that were missed. The MDSC stated the incident with R2 slipped through the cracks. During an interview on 10/30/24 at 2:30 PM, the Director of Nursing (DON) said after any resident-to-resident incident, staff should beware of the incident and what solutions were put into place. She said the incident should have been care planned. During an interview on 10/30/24 at 2:50 PM, the Administrator said after R2 hit another resident there should have been a care plan implemented with interventions.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure staff maintained professional standards of practice by ensuring 1 of 13 residents (Resident (R) 3) was free from medication errors when staff administered R3 two melatonin pills instead of two oxycodone pills. Findings included:	F 658	F658 1. Resident # 3 received the incorrect medication by LPN1 with no adverse reactions. At the time of the found incident LPN 1 was provided with corrective action by the Director of Nursing 2. Current residents are at risk. 3. Current licensed nurses and Certified Medication aides will receive education on	11/16/24

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F 658	Continued From page 14	F 658		

Review of R3's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), revealed admission to the facility on 08/06/18 with diagnoses including insomnia and chronic pian.

Review of R3's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 10/11/24 and located under the "Resident" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating no cognitive impairment.

Review of the facility's "Incident Report" log, provided by the facility and dated 10/29/24, revealed no medication errors for R3 within the month of October 2024.

Review of R3's "Orders," located under the "Resident" tab of the EMR, revealed a physician order, dated 10/05/24, for "melatonin 10 mg (milligrams); 1 tab at bedtime," and "oxycodone 5 mg; 2 tablets as needed for pain every 4 hours."

During an interview on 10/28/24 at 12:18 PM, R3 said that the nurse gave him melatonin instead of his pain medications on 10/14/24. R3 stated he waited until she left the room so that he could see what they were, and then he told a CNA about it. R3 could not identify which CNA he reported the incident to.

During an interview on 10/29/24 at 4:13 PM, Licensed Practical Nurse (LPN)1 said she almost made a medication error on 10/14/24. She stated she was supposed to administer oxycodone to R3, but she accidentally gave him two melatonin pills instead. She said R3 told a Certified Nurse Aide (CNA) first about what happened, and then

the 5 rights and will receive a medication observation competency completed by Director of Nursing or designee. This will be completed by 11/15/2024. Agency licensed nurses or certified medication aides will receive education and med observation skills competency prior to the beginning of their shift. Any licensed nurse or Medication aide not receiving education or medication pass observation will not be allowed to work until items completed. Any new licensed nurse and certified medication aide will receive the education and have a medication observation competency during the orientation process.

4. Director of Nursing or designee will complete 5 med pass observations across all shifts weekly x 12 weeks.
5. The Director of Nursing will report the results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes.
6. Date of Completion 11/16/2024

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the CNA came and told her. She said she gave the two tabs of melatonin to R3 in a cup, and she watched him swallow them, or she thought he had swallowed the pills. She said the CNA came and told her that she gave him melatonin by accident. LPN1 stated that after she left the room, R3 spit out the pills and reported that to the CNA. LPN1 stated she went back into his room and took the melatonin pills from him and administered the oxycodone to him. She said she told the Administrator that she almost administered the wrong medication to R3. LPN1 stated she did not complete an incident report or a medication error report because she did not think it was a medication error since R3 did not actually swallow the melatonin. LPN1 stated she had R3 give her the medication so that she could look at it and try and determine what they were. LPN1 could not identify which CNA had reported the incident to her.

Review of R3's narcotic count sheet revealed the number of remaining pills of oxycodone was correct for the administration that occurred on 10/14/24.

During an interview on 10/30/24 at 2:30 PM, the Director of Nursing (DON) stated it was a medication error after LPN1 gave R3 the wrong medication and left the room under the assumption that he had swallowed them. She stated she expected nursing staff to ensure the five rights of medication administration, and if staff feel like they have given the wrong medication, an incident report should have been completed.

During an interview on 10/30/24 at 2:50 PM, the Administrator stated she was not told that R3 was

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F 658	Continued From page 16 administered the wrong pills and that the nurse left his room. She stated that was not the story that was relayed to her. The Administrator stated it was a medication error, and there should have been a medication error report completed, and the physician should have been notified. She stated she expected staff to follow physician orders and administer medications per physician orders.	F 658		