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	345194	A. BUILDING _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

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E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the	E 037		3/20/20

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

Electronically Signed | 03/18/2020

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E 037	Continued From page 1	E 037		

procedures necessary to protect patients and others.

(v) Maintain documentation of all emergency preparedness training.

(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training every 2 years.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency

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E 037	Continued From page 2	E 037		

preparedness training.

(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected

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E 037	Continued From page 3 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the faciltiy failed to conduct annual emergency preparedness in-servicing with it's staff members. Findings included: Review of the facility's emergency preparedness notebook revealed there was no evidence that staff members were receiving annual in-servicing about emergency procedures related to different types of emergency situations. During an interview with the Administrator on 02/27/20 at 3:03 PM he stated employees received education about emergency preparedness during orientation. He reported the	E 037	GlenFlora acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. GlenFlora response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, GlenFlora reserves the right to refute any of the deficiencies on this Statement of	

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E 037	Continued From page 4 Maintenance Manager conducted this in-servicing. However, he commented he did not realize that staff members were required to receive annual emergency preparedness education, but remarked that it made sense that employees receive refreshers about their responsibilities during different emergency situations. During an interview with the facility's Maintenance Manager on 02/27/20 at 3:16 PM he stated during orientation he reviewed staff responsibilities, based on disciplines/departments, during all types of emergencies including inclement weather, active shooter situations, acts of terrorism, fires, etc. However, he commented he did not provide any follow-up education to staff members after orientation about emergency preparedness other than conducting fire drills on alternating shifts.	E 037	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. E037 EP Training Program The process that led to this deficiency is the facility failed to conduct annual emergency training with all staff members on emergency procedures related to different types of emergency situations. On 3/9/2020, the Executive Director initiated in-service training with all staff members of each department on their specific roles, duties, and procedures related to each emergency disaster listed in the emergency preparedness plan. All in-servicing will be completed by 3/20/2020 and any staff member not in-serviced will be in-serviced prior to next scheduled shift by the Maintenance Director. On 3/11/2020, the Maintenance Director conducted an Elopement Drill. Staff members from all departments adhered to the procedure and followed their duties as written in the emergency preparedness plan. No areas of concern identified. Any newly hired staff members will be in-serviced by the Maintenance Director on the emergency preparedness job duties and responsibilities during the orientation process. The Maintenance Director will begin	

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E 037	Continued From page 5	E 037	annual Emergency Preparedness training in September 2020 for all staff members and complete annually every September. Training will include how to respond to specific disasters and emergencies, and each department's specific roles, duties and procedures. Documentation of emergency preparedness training will be kept on file in the Maintenance Director's office. The Maintenance Director will conduct an unannounced Disaster Drill with facility staff to test the Emergency Preparedness plan quarterly for one year utilizing the Emergency Preparedness Audit. The Maintenance Director will forward the results of the audit to the Executive Quality Improvement Committee quarterly for a year. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/24/20 through 2/27/20. Event ID# 0Q2J11. Six of 6 complaint allegations were unsubstantiated.	F 000		
F 684	Quality of Care	F 684		3/20/20

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F 684 SS=D	Continued From page 6 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 staff interview and record review the facility failed to complete acute charting regarding chewing/swallowing for 1 of 1 sampled residents (Resident #8) who experienced a "near-choking" episode followed by an actual choking incident. Findings included: Resident #8 was admitted to the facility on 02/05/18. Her documented diagnoses included cerebrovascular accident (CVA) with aphasia, transient ischemic attacks, trigeminal neuralgia, and generalized anxiety disorder. Resident #8's 08/30/19 quarterly minimum data set (MDS) documented her cognition was severely impaired, she required limited assistance by a staff member with eating, and she had no swallowing issues. Vital signs taken at 9:40 AM on 11/18/19 documented Resident #8's blood pressure was 108/70, her temperature was 98.3, her pulse was 80, and her respirations were 20. A 11/18/19 2:15 PM progress note documented, "Resident whines out at intervals when	F 684	F684 Quality of Care The process that led to this deficiency is the facility failed to complete post-acute charting regarding chewing/swallowing for one on of one sampled resident who experienced a “near-choking” episode followed by an actual choking incident. On 3/16/2020, the Director of Nursing audited all incidents from previous 14 days. There were 10 incidents which required post-acute charting and all incident documentation and post-acute charting was completed accurately and timely. On 3/16/2020, the Director of Nursing initiated in-service with all nurses on the importance of accurately documenting on all incidents and/or acute conditions. In-service will be completed with all nurses by 3/20/2020 and any nurse not in-serviced will be in-serviced prior to next scheduled shift by Director of Nursing.	

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F 684	Continued From page 7 medications are given and holds hand over mouth. All medications taken. No swallowing difficulty noted." In a 11/20/19 1:45 AM progress note Nurse #1 documented, "Elder placed on acute monitoring r/t (due to) near choking incident on (11/18/19). Swallowing without difficulty this shift. Took meds crushed in applesauce without difficulty." (Review of progress notes and change of condition notes from 11/18/19 revealed there was no documentation about a near-choking episode that occurred on that date. Review of staffing schedules revealed Nurse #2 was assigned to care for Resident #8 from 7:00 AM until 7:00 PM on 11/18/19). Review of lab and x-ray results revealed Resident #8 had frontal and lateral radiographs (x-rays) of the chest taken on 11/19/19 secondary to "choking". Findings documented, "Lungs are clear without mass, consolidation, or effusion. No pneumothorax." Vital signs taken at 2:47 PM on 11/21/19 documented Resident #8's blood pressure was 126/72, her temperature was 97.5, her pulse was 78, and her respirations were 18. A 11/22/19 4:28 PM progress note documented, "This writer called to resident's room at 8:15 AM by nursing assistant feeding resident breakfast. Resident continuous coughing as if choking. Resident suctioned several times per DON (Director of Nursing), clear frothy mucous obtained. Vitals: 97.9 (temperature), 88 (pulse), 24 (respirations), 134/90 (blood pressure). (Oxygen saturation) at 89%, oxygen placed on at 2 liters per minute increasing sats to 91 - 92%,	F 684	Any newly hired nurse will be in-serviced on the importance of accurately documenting on all incidents and/or acute conditions during the orientation process. The Director of Nursing will audit any new incidents and any new acute conditions to ensure that appropriate documentation is completed and follow-up is being completed. The Acute Condition audit will occur 5 times a week for 4 weeks, then weekly for four weeks, and monthly for two months. The Director of Nursing will forward the results of the Acute Charting audits to the Executive Quality Improvement Committee monthly for four months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions.	

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F 684	Continued From page 8	F 684		

skin color slightly pale, less coughing noted. Doctor informed of choking episode by this writer. Therapy in room with resident at 8:50 AM, blood pressure 96/74, (oxygen saturation) at 79%. This writer informed DON of 8:50 AM assessment. RP (responsible party) contacted and informed of 8:50 AM assessment, and wants resident sent out to hospital...."

11/25/19 hospital study results documented, "Video fluoroscopic barium swallow showed no aspiration or penetration..."

Resident #8's 12/04/19 annual MDS documented her cognition was severely impaired, she required extensive assistance by a staff member with eating, she experienced coughing and choking during meals, and she complained of difficulty or pain with swallowing.

During a telephone interview with Nurse #2 on 02/26/20 at 3:59 PM she stated she was not aware of Resident #8 having a choking episode prior to the one on 11/22/19. However, she reported a family member of Resident #8 commented the same nursing assistant (NA) who fed the resident on 11/22/19 "was the one feeding her before." She commented she gathered from the family's comment that there was a previous episode during which the resident experienced some type of difficulty eating.

During an interview with Nurse #1 on 02/27/20 at 8:21 AM she reported she worked from 7:00 PM until 7:00 AM, and she received report from the departing nurse on the night of 11/18/19 that Resident #8 had some type of choking event at breakfast on 11/18/19, and the resident was to be placed on acute charting due to this event.

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F 684	Continued From page 9 However, she commented she could not remember which nurse gave her the 11/18/19 report. She stated when a resident was placed on acute charting a nurse was supposed to assess the resident every shift; in this case assessing how the resident was swallowing medications and chewing and swallowing her food. During an interview with the Director of Nursing (DON) on 02/27/20 at 8:30 AM she stated when residents were placed on acute charting vital signs were taken and nursing assessments were completed each shift. After reviewing Resident #8's electronic medical record, she stated acute charting was not completed for this resident after a reported "near-choking" episode on the morning of 11/18/19. She commented nursing did not take vital signs and did not evaluate the resident's swallowing each shift, and the resident had another apparent episode of choking documented on 11/22/19.	F 684		
F 758 SS=D	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---	F 758		3/20/20

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F 758	Continued From page 10 §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 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 staff interviews, the facility failed to discontinue or consider continued use with rationale and duration for PRN (as needed) psychotropic medications after 14 days	F 758	F758 Free from Unnec Psychotropic Meds/ PRN Use The process that led to this deficiency is	

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F 758	Continued From page 11 for 2 of 5 residents (Resident #147 and Resident #40) reviewed for unnecessary medications. Findings included: 1. Resident #147 was admitted to the facility on 02/11/20. Diagnoses included, in part, insomnia. The Minimum Data Set (MDS) 5 day assessment dated 02/18/20 revealed the resident was mildly cognitively impaired. Resident #147 demonstrated no mood or behaviors and had received 7 days of an antidepressant, 5 days of hypnotic (sedative), 6 days of an anticoagulant (blood thinner), and 4 days of opioid medications (narcotic pain medications). A review of the physician ' s order written on 02/11/20 revealed an order for Zolpidem Tartrate, also known as Ambien, (hypnotic medication to aid with sleeping) 5 milligrams (mg) one tablet by mouth at night as needed (PRN) for insomnia. The Medication Administration Record (MAR) for the month of February, 2020, revealed the resident received the medication on 2/13, 2/14, 2/15, 2/17, 2/18, 2/19, 2/20, 2/21 and 2/22 as evidenced by a documented time stamp of when the medication was given. There was no stop date indicated on the MAR. A pharmacy medication review on 02/21/20 revealed a recommendation for the ordered Ambien 5 mg for Resident #147 needed a stop date. The physician notes revealed there was no documentation to address continuing the Ambien PRN medication beyond 14 days.	F 758	the facility failed to discontinue or consider continued use with rationale and duration for PRN (as needed) psychotropic medications after 14 days. On 2/25/2020 an LPN administrative nurse discontinued one medication for Resident #147 and obtained a rationale for the Resident #40 physician order. On 2/25/2020, two LPN administrative nurses completed medication review of all residents to verify all physician orders included stop dates on all PRN psychotropic medications, and diagnosis for use. All PRN psychotropic medications had stop dates and diagnosis for use. On 3/16/2020, the Director of Nursing initiated verbal education with all nurses explaining that all PRN psychotropic medication physician orders must have 14 day stop date and cannot be renewed unless the attending physician or prescribing physician evaluates the resident for the appropriateness of that medication. All nurses will be in-serviced by 3/20/2020 and any nurse not in-serviced will be in-serviced by the Director of Nursing prior to their next scheduled shift. Any newly hired nurse will be in-serviced on 14-day stop date for all PRN medications prescribed that must include a diagnosis for use during the orientation process. The admissions nurse will audit all new	

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F 758	Continued From page 12 An interview was conducted with Nurse #3 on 02/27/20 at 2:55 PM. Nurse #3 stated whenever a physician ordered a psychotropic medication such as Ambien to be given PRN, the physician should have a stop date of 14 days to reassess the resident as to whether or not to continue the medication. Nurse #3 stated the order for the Ambien did not have a stop date and the nursing staff should have clarified the order with the physician. Nurse #3 confirmed the stop date should have been 02/25/20. An interview with the facility ' s Pharmacy Consultant via phone on 02/27/20 at 3:10 PM revealed that any PRN psychotropic medication should have a stop date of 14 days from the order unless the facility physician could provide rationale as to why the resident should continue the medication. The Pharmacist stated the order for the Ambien was written on 02/11/20 and should have had a stop date of 02/25/20. An interview was conducted with Director of Nursing (DON) on 02/27/20 at 4:05 PM. The DON reported the admissions nurse completed all the second checks on all physician orders and added, the order for the Ambien somehow got missed. The DON stated the staff nurses were aware if there was a PRN order for a psychotropic medication, it had to have a 14 day stop date. The DON stated her expectation was for the nursing staff to clarify with the physician and add a stop date to the order. 2. Resident #40 was admitted to the facility on 02/04/20. Diagnoses included, in part, chronic pain and insomnia.	F 758	PRN psychotropic medication orders utilizing the psychotropic medication audit tool to ensure all physician orders have a 14-day stop date and a diagnosis for use. The audit will occur three times a week for four weeks, weekly for four weeks and monthly for two months. The admissions nurse will forward the results of the psychotropic medication audit to the Executive Quality Improvement Committee monthly for 4 months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345194	A. BUILDING _____ B. WING _____	C 02/27/2020

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F 758	Continued From page 13	F 758		

The MDS 5 day assessment dated 02/11/20 revealed the resident was cognitively aware. Resident #40 demonstrated no behaviors and had received 7 days of an antidepressant, 5 days of hypnotic (sedative), 7 days of an anticoagulant, and 7 days of opioids.

A review of the physician ' s order written on 02/04/20 revealed an order for Triazolam, also known as Halcion, (hypnotic medication) 0.25 mg one tablet by mouth at bedtime PRN for insomnia due to restlessness with pain.

A record review of the January and February MARs revealed the resident was receiving the Halcion frequently as evidenced by a documented time stamp of when the medication was given. The MARs did not indicate there was a stop date for the PRN Halcion medication.

A pharmacy recommendation submitted to the facility on 02/24/20 via fax revealed the Halcion 0.25 mg by mouth at bedtime PRN for insomnia should be discontinued; or if continued use was appropriate, to provide the rationale and duration. The facility physician agreed to continue the medication for 60 days for insomnia due to restlessness with pain and signed the recommendation on 02/24/20.

An interview was conducted with Nurse #3 on 02/27/20 at 2:55 PM. Nurse #3 stated whenever a physician ordered a psychotropic medication such as Halcion to be given PRN, the physician should have a stop date of 14 days to reassess the resident as to whether or not to continue the medication. Nurse #3 stated the order for the Halcion did not have a stop date and the nursing staff should have clarified the order with the

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F 758	Continued From page 14 physician. Nurse #3 confirmed the stop date for the Halcion should have been 02/18/20. An interview with the facility ' s Pharmacy Consultant via phone on 02/27/20 at 3:10 PM revealed any PRN psychotropic medication should have a stop date of 14 days from the order unless the facility physician could provide rationale as to why the resident should continue the medication. The Pharmacy Consultant stated the physician should either discontinue the medication or continue PRN for 60 days. The Pharmacy Consultant stated the order was written on 02/04/20 and should have had a stop date of 02/18/20. An interview was conducted with DON on 02/27/20 at 4:05 PM. The DON reported the admissions nurse completed all the second checks on all physician orders and added, the order for the Halcion somehow got missed. The DON stated the staff nurses were aware if there was a PRN order for a psychotropic medication, it had to have a 14 day stop date. The DON stated her expectation was for the nursing staff to clarify with the physician and add a stop date to the order.	F 758		
F 759 SS=E	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 observations, record review and staff	F 759	F759 Free of Medication Error Rates 5	3/20/20

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F 759	Continued From page 15 interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 12 medications that were administered late out of 25 observations resulting in a medication error rate of 48% for 2 of 2 residents (Resident #147 and Resident #6) observed during a medication pass. Findings included: During a medication pass observation with Nurse #3 in 02/24/20 at 11:55 AM, Nurse #3 was observed administering the following medications to Resident #147: one tablet of Diltiazem 60 milligrams (mg), one tablet of Dronabinol 2.5 mg, one tablet of Famotidine 20 mg, one tablet of Metoprolol Tartrate 25 mg, one tablet of Bactrim DS 800 mg, and one tablet of Methocarbamol 500 mg. 1a.A medication reconciliation was conducted on 02/24/20 at 1:05 PM. The reconciliation revealed the Bactrim DS and the Methocarbamol medications were due to be administered at 8:00 AM. The Diltiazem, Dronabinol, Famotidine, and the Metoprolol Tartrate medications were due to be administered at 9:00 AM. The Diltiazem was scheduled to be administered four times per day at 9:00 AM, 3:00 PM, 9:00 PM and 3:00 AM. The Methocarbamol was scheduled to be administered three times per day at 8:00 AM, 4:00 PM and 8:00 PM. An interview was conducted with Nurse #3 on 02/25/20 at 5:35 PM. Nurse #3 reported the way the system worked with their new computer system was that the nurses had a time block to complete their medication pass. Nurse #3 explained all the AM medications that were due	F 759	Percent or More The process that led to this deficiency was the facility failed to ensure the medication error rate was 5% or less. There were 25 observations and 12 medications administered late resulting in a medication error rate of 48%. Resident #147 and Resident #6 did not have any adverse outcomes from receiving the late medications. The facility obtained a physician's order liberalize medication pass and all residents' medication times transition to patient-centered care times on 3/3/2020. The Director of Nursing verbally educated all nurses on 3/3/2020. On 3/16/2020, the Director of Nursing initiated medication pass audits with all nurses. All nurses will have a medication pass audit completed by the Director of Nursing on 3/20/2020. Any nurse who have not had a medication pass audit by 3/20/2020 must be audited during their next scheduled shift by the Director of Nursing. Any newly hired nurse will be in-serviced on the patient centered times for medication administration during the orientation process. On 3/16/2020, all nurses, including Licensed Practical Nurse #3 was in-serviced by the Director of Nursing on the seven rights of medication administration including correct time to	

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F 759	Continued From page 16 from 7:00 AM through 9:00 AM needed to be administered by 10:30 AM according to the time block on the electronic medical administration record (eMAR). Nurse #3 stated she realized she administered the medications late when she gave them to Resident #147 at 12:00 PM. Nurse #3 stated she kept getting called away from her medication cart and it caused her to be late. During a medication pass observation with Nurse #3 on 02/24/20 at 5:55 PM, Nurse #3 was observed administering the following medications to Resident #147: one tablet of Diltiazem 60 mg, one tablet of Methocarbamol 500 mg, and three tablets of Vitamin D3 (1,000 units per tablet). 1b.A medication reconciliation was conducted for Resident #147 on 02/24/20 at 6:15 PM. The reconciliation revealed the Diltiazem and the Vitamin D3 were scheduled to be administered at 3:00 PM. The Methocarbamol was due to be administered at 4:00 PM. During a medication pass observation with Nurse #3 on 02/25/20 at 5:30 PM, Nurse #3 was observed administering the following medications to Resident #147: one tablet of Diltiazem 60 mg, one tablet of Methocarbamol 500 mg, and three tablets of Vitamin D3 (1,000 units per tablet). 1c.A medication reconciliation was conducted for Resident #147 on 02/25/20 at 6:00 PM. The reconciliation revealed the Diltiazem and the Vitamin D3 were scheduled to be administered at 3:00 PM. The Methocarbamol was due to be administered at 4:00 PM. An interview was conducted with Nurse #3 on 02/25/20 at 5:35 PM. Nurse #3 reported the way	F 759	administer medications and the liberalized medication pass times. Any nurse not in-serviced by 3/20/2020 will be in-serviced prior to beginning next shift by the Director of Nursing. The Director of Nursing or the AL Coordinator nurse will audit 25% of nurses administering medications utilizing the Medication Pass Evaluation audit tool to ensure that medications are administered timely. The Director of Nursing or the Minimum Data Set nurse will complete medication pass audits with 25% of nurses weekly for eight weeks, then monthly for two months. The Director of Nursing will forward the results of the Medication Pass Evaluation audits to the Executive Quality Improvement Committee monthly for four months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	

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F 759	Continued From page 17	F 759		

the system worked with their new computer system was that the nurses had a time block to complete their medication pass. Nurse #3 explained all the medications that were due between 3:00 PM and 6:00 PM had to be given by 6:00 PM according to the time block on the electronic medical administration record (eMAR). Nurse #3 stated she did not realize the Diltiazem had prescribed times to be given four times daily. Nurse #3 also reported she did not realize the Methocarbamol had prescribed times to be given three times daily. Nurse #3 stated the facility did not follow the protocol with administering medications one hour before they were due or one hour after they were due. Nurse #3 stated with the new eMAR system they now used the time blocks.

During a medication pass observation of Nurse #4 on 02/26/20 at 10:45 AM, Nurse #4 was observed administering the following medication to Resident #6: one tablet of Levetiracetam 500 mg, one tablet of Carvedilol 6.25 mg and one tablet of Gabapentin 300 mg.

An interview was conducted with Nurse #4 on 02/26/20 at 10:50 AM. Nurse #4 reported the protocol for administering the medications was nurses had one hour before the scheduled medication was due to give the medication or one hour after the scheduled medication was due to be given. Nurse #4 reported she had no knowledge of administering medications in a time block.

2a.A medication reconciliation was conducted for Resident #6 on 02/26/20 at 11:00 AM. The reconciliation revealed the medications were due at 10:00 AM. These medications were

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F 759	Continued From page 18 administered on time. An interview was conducted with Director of Nursing (DON) on 02/27/20 at 4:05 PM. The DON reported the protocol for medication pass administration times was the nursing staff had one hour before the medication was due and one hour after the medication was due to be administered. The DON reported the current system did not have a liberal medication time pass and it was her expectation of the nursing staff to administer the medications as ordered per the eMAR prescribed times and the facility protocol.	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		3/20/20

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F 812	Continued From page 19 Based on observation and staff interview the facility failed to air dry kitchenware before stacking it in storage and failed to discard abraded kitchenware being used for serving residents their food. Findings included: 1. During observation of the kitchen on 02/26/20 at 8:54 AM 1 of 15 tray pans stacked on top of one another in storage had moisture inside of it. During observation of the kitchen on 02/26/20 at 8:56 AM 4 of 8 salad bowls were stacked on top of one another in storage with moisture trapped between them. During an interview with the Dietary Manager (DM) on 02/27/20 at 10:32 AM she reported she thought the kitchenware items found stacked wet on the morning of 02/26/20 had actually been placed into storage on the evening of 02/25/20. She stated dietary staff had been previously in-serviced that kitchenware should be clean and dry before being stacked in storage. She commented trapped moisture was a breeding ground for bacteria which had the potential of making residents sick. During an interview with Dietary Employee #1 on 02/27/20 at 10:43 AM she stated dietary staff had been told not to stack kitchenware wet because germs and mold could form in the moisture which could cross-contaminate food. 2. During observation of the kitchen on 02/26/20 at 9:40 AM 18 of 32 (56%) plastic soup and cereal bowls had abraded interior surfaces. During an interview with the Dietary Manager	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary The process that led to this deficiency was the facility failed to air dry kitchenware before stacking it in storage and failed to discard abraded kitchenware being used for serving residents their food. On 2/26/2020, the Dietary Manager discarded all abraded kitchenware and on 3/2/2020 ordered new bowls from US Foods to replace the discarded bowls. On 3/9/2020, the Executive Director initiated in-service training with all dietary staff on the importance of air-drying kitchenware prior to stacking in storage and the negative health consequences associated with failing to do so. The dietary staff was also educated on notifying the Dietary Manager of any abraded kitchenware and discarding kitchenware after notifying the Dietary Manager. The Dietary Manager will order new kitchenware to replace any abraded kitchenware as deemed necessary. In-service will be completed by 3/20/2020 and any staff member not in-serviced will be in-serviced prior to next scheduled shift by the Executive Director. Any newly hired dietary staff will be in-serviced by the Dietary Manager on the importance of air-drying kitchenware prior to stacking in storage with the negative health consequences and the process of discarding abraded kitchenware while	

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F 812	Continued From page 20 (DM) on 02/27/20 at 10:32 AM she reported abraded kitchenware surfaces could harbor bacteria, and pieces of abraded plastic could slough off into food. She commented dietary staff had been told not to heat soups in the microwave which was what she thought was causing the deterioration of the interior bowl surfaces. She stated dietary staff were trained to dispose of compromised kitchenware after they showed it to her for validation and a count for re-order. During an interview with Dietary Employee #1 on 02/27/20 at 10:43 AM she stated dietary staff were trained to throw away kitchenware that was cracked, chipped, or had abrasions inside of it. She reported germs and bacteria were more difficult to remove from compromised kitchenware surfaces, and in the case of the plastic soup and cereal bowls, tiny pieces of plastic could choke residents as they were eating from the bowls. She commented bowls with abraded interior surfaces posed both a sanitation and a safety risk.	F 812	notifying the Dietary Manager. On 3/9/2020, the Registered Dietician completed a sanitation inspection of the kitchen including inspection of all stacked kitchenware for appropriate air-drying technique and abraded kitchenware. No issues were discovered. The Executive Director will audit stored stacked kitchenware for appropriate air-drying technique and audit for abraded kitchenware utilizing the Dietary audit tool. The audit will be completed weekly for 8 weeks and monthly for two months. The Executive Director will forward the results of the Dietary audits to the Executive Quality Improvement Committee monthly for four months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 842 SS=D	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	F 842		3/20/20

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F 842	Continued From page 21	F 842		

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-
(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.

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F 842	Continued From page 22 §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 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to: 1) accurately document the actual time of medication administration during 3 out of 3 observations for one resident (Resident #147) observed during a medication pass, and 2) failed to document the details of a near-choking episode for 1 of 1 residents (Resident #8) who experienced a near-choking episode. Findings included: During a medication pass observation with Nurse #3 in 02/24/20 at 11:55 AM, Nurse #3 was observed administering the following medications to Resident #147: one tablet of Diltiazem 60 milligrams (mg), one tablet of Dronabinol 2.5 mg,	F 842	F842 Resident Record- Identifiable Information The process that led to this deficiency was the facility failed to: 1) accurately document the actual time of medication administration during 3 out of 3 observations for one resident observed during a medication pass, and 2) failed to document the details of a near-choking episode of one of one resident who experienced a near-choking episode. The facility obtained a physician's order liberalize medication pass and all residents' medication times transition to patient-centered care times on 3/3/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 23 one tablet of Famotidine 20 mg, one tablet of Metoprolol Tartrate 25 mg, one tablet of Bactrim DS 800 mg, and one tablet of Methocarbamol 500 mg. 1a.A medication reconciliation was conducted on 02/24/20 at 1:05 PM. The reconciliation revealed the Bactrim DS and the Methocarbamol medications were due to be administered at 8:00 AM. The Diltiazem, Dronabinol, Famotidine, and the Metoprolol Tartrate medications were due to be administered at 9:00 AM. A review of the Medication Administration Record (MAR) revealed the medications Nurse #3 was observed giving to Resident #147 0n 02/24/20 at 12:00 PM were checked off in the MAR at 8:00 AM and 9:00 AM as evidenced by her initials. An interview was conducted with Nurse #3 on 02/25/20 at 5:35 PM. Nurse #3 reported the way the system worked with their new computer system was that the nurses had a time block to complete their medication pass. Nurse #3 explained all the AM medications that were due from 7:00 AM through 9:00 AM needed to be administered by 10:30 AM according to the time block on the electronic medical administration record (eMAR). Nurse #3 stated she realized she administered the medications late when she gave them to Resident #147 at 12:00 PM. Nurse #3 stated she kept getting called away from her medication cart and it caused her to be late. Nurse #3 stated she was not aware of any way to put the actual time in the eMAR that a medication was given. Nurse #3 stated if there was a way, she was not aware of it with this new system. During a medication pass observation with Nurse	F 842	The Director of Nursing verbally educated all nurses on 3/3/2020. On 3/16/2020, the Director of Nursing audited all incidents from previous 14 days. There were 10 incidents which required post-acute charting and all incident documentation and post-acute charting was completed accurately and timely. On 3/16/2020, the Director of Nursing initiated in-service with all nurses on the importance of accurately documenting on all incidents and/or acute conditions and the liberalized medication pass times. In-service will be completed with all nurses by 3/20/2020 and any nurse not in-serviced will be in-serviced prior to next scheduled shift by Director of Nursing. Any newly hired nurse will be in-serviced on the importance of accurately documenting on all incidents and/or acute conditions and giving medications timely during the orientation process. The Director of Nursing will audit any new incidents and any new acute conditions to ensure that appropriate documentation is completed and follow-up is being completed. The Acute Condition audit will occur 5 times a week for 4 weeks, then weekly for four weeks, and monthly for two months. The Director of Nursing or the AL Coordinator nurse will audit 25% of nurses administering medications utilizing	

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	345194	A. BUILDING _____ B. WING _____	C 02/27/2020

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F 842	Continued From page 24 #3 on 02/24/20 at 5:55 PM, Nurse #3 was observed administering the following medications to Resident #147: one tablet of Diltiazem 60 mg, one tablet of Methocarbamol 500 mg, and three tablets of Vitamin D3 (1,000 units per tablet). 1b.A medication reconciliation was conducted for Resident #147 on 02/24/20 at 6:15 PM. The reconciliation revealed the Diltiazem and the Vitamin D3 were scheduled to be administered at 3:00 PM. The Methocarbamol was due to be administered at 4:00 PM. A review of the Medication Administration Record (MAR) revealed the medications Nurse #3 was observed giving to Resident #147 0n 02/24/20 at 5:55 PM were checked off in the MAR at 3:00 PM and 4:00 PM as evidenced by her initials. During a medication pass observation with Nurse #3 on 02/25/20 at 5:30 PM, Nurse #3 was observed administering the following medications to Resident #147: one tablet of Diltiazem 60 mg, one tablet of Methocarbamol 500 mg, and three tablets of Vitamin D3 (1,000 units per tablet). 1c.A medication reconciliation was conducted for Resident #147 on 02/25/20 at 6:00 PM. The reconciliation revealed the Diltiazem and the Vitamin D3 were scheduled to be administered at 3:00 PM. The Methocarbamol was due to be administered at 4:00 PM. A review of the Medication Administration Record (MAR) revealed the medications Nurse #3 was observed giving to Resident #147 0n 02/25/20 at 5:30 PM were checked off in the MAR at 3:00 PM and 4:00 PM as evidenced by her initials.	F 842	the Medication Pass Evaluation audit tool to ensure that medications are administered timely. The Director of Nursing or the Minimum Data Set nurse will complete medication pass audits with 25% of nurses weekly for eight weeks, then monthly for two months. The Director of Nursing will forward the results of the Acute Charting audits and the Medication Pass Evaluation audits to the Executive Quality Improvement Committee monthly for four months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	

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F 842	Continued From page 25	F 842		

An interview was conducted with Nurse #3 on 02/25/20 at 5:35 PM. Nurse #3 reported the way the system worked with their new computer system was that the nurses had a time block to complete their medication pass. Nurse #3 explained all the medications that were due between 3:00 PM and 6:00 PM had to be given by 6:00 PM according to the time block on the electronic medical administration record (eMAR). Nurse #3 stated with the new eMAR system they now used the time blocks. Nurse #3 stated she was not aware of any way to put the actual time in the eMAR that a medication was given. Nurse #3 stated if there was a way, she was not aware of it with this new system.

An interview was conducted with the Director of Nursing (DON) on 02/27/20 at 4:05 PM. The DON reported the protocol for medication pass administration times was the nursing staff had one hour before the medication was due and one hour after the medication was due to be administered. The DON reported the current system did not have a liberal medication time pass and it was her expectation of the nursing staff to administer the medications as ordered per the eMAR prescribed times and the facility protocol and to sign the medication off at the time it was given. The DON stated she expected her nursing staff to have working knowledge of the computer system and the eMAR program in order to be efficient and have accurate documentation.

2. Resident #8 was admitted to the facility on 02/05/18. Her documented diagnoses included cerebrovascular accident (CVA) with aphasia, transient ischemic attacks, trigeminal neuraliga, and generalized anxiety disorder.

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F 842	Continued From page 26	F 842		

In a 11/20/19 1:45 AM progress note Nurse #1 documented, "Elder placed on acute monitoring r/t (due to) near choking incident on (11/18/19). Swallowing without difficulty this shift. Took meds crushed in applesauce without difficulty."

Review of progress notes and change of condition notes from 11/18/19 revealed there was no documentation about a near-choking episode that occurred on that date.

Review of staffing schedules revealed Nurse #2 was assigned to care for Resident #8 from 7:00 AM until 7:00 PM on 11/18/19.

Review of lab and x-ray results revealed Resident #8 had frontal and lateral radiographs (x-rays) of the chest taken on 11/19/19 secondary to "choking".

During a telephone interview with Nurse #2 on 02/26/20 at 3:59 PM she stated she was not aware of Resident #8 having a choking episode prior to the one on 11/22/19. However, she reported a family member of Resident #8 commented the same nursing assistant (NA) who fed the resident on 11/22/19 "was the one feeding her before." She commented she gathered from the family's comment that there was a previous episode during which the resident experienced some type of difficulty eating.

During an interview with Nurse #1 on 02/27/20 at 8:21 AM she reported she worked from 7:00 PM until 7:00 AM, and she received report from the departing nurse on the night of 11/18/19 that Resident #8 had some type of choking event at breakfast on 11/18/19, and the resident was to be

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F 842	Continued From page 27	F 842		

placed on acute charting due to this event. However, she commented she could not remember which nurse gave her the 11/18/19 report. She stated when an event as serious as one involving choking occurred she thought the nurse who assessed the resident should have at least written a progress note to provide details about what happened.

During an interview with the Director of Nursing (DON) on 02/27/20 at 3:16 PM she stated a nurse should have written a progress note on 11/18/19 regarding what she meant by a "near-choking" event. She reported details of the event were important so that the facility could develop interventions to prevent a similar event from happening in the future.