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	345420	A. BUILDING _____ B. WING _____	C 09/19/2022

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E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004		11/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/13/2022

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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual updates and review of the facility ' s Emergency Preparedness Plan. This failure had the potential to affect all staff and residents. Findings included: A review of the facility ' s Emergency Preparedness (EP) Plan occurred on 9/15/22 on 12:22 PM, with the Maintenance Director. During the review, it was discovered the emergency plan had not been updated since 4/13/21. Emergency contact information, risk assessment, communication systems, annual training or required exercises for staff on the EP plan at this facility had not been done. The Maintenance Director stated he assumed the position in February 2022 and had not been officially trained on the responsibilities of the EP program. He confirmed there was no documentation of the required updates, annual training, or exercises for staff. An interview was conducted on 9/15/22 at 2:45PM, the Nursing Home Administrator (NHA) explained she was new to the facility and was unaware the EP manual had not been updated in	E 004	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. E004 1. Review of Emergency preparedness manual has been completed 2. Current Residents in the center have the potential to be affected. 3. The Director of Maintenance/Administrator have been educated by the Regional Maintenance Director/designee on reviewing and updating the Emergency Preparedness Manual annually. 4. Administrator or designee will ensure manual has been updated and documentation of staff training or exercises for emergency preparedness are completed at least annually 5. Updates/revisions to the Emergency	

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E 004	Continued From page 2 the last 12 months and there was no documentation of staff training or exercises for emergency preparedness. The NHA stated she expected the EP manual to be updated annually to include staff training and exercises as required.	E 004	Preparedness Manual will be reviewed in the monthly QAPI to ensure any potential changes have been incorporated/reviewed and signed as appropriate. Date of completion : 11/2/2022	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 09/12/22 through 09/19/22. Event ID# OVIT11. The following intakes were investigated: NC00193180 ; NC00193199 ; NC00192901 ; NC00192855 ; NC00192360 ; NC00192251 ; NC00192272 ; NC00192154 ; NC00191895 ; NC00191888; NC00191710 ; NC00191480 ; NC00191263 ; NC00191011 ; NC00190900; NC00190878 ; NC00190846 ; NC00190737; NC00190568 ; NC00190320 ; NC00190037 ; NC00189750 ; NC00189445 ; NC00189269 ; NC00189241 ; NC00188842 ; 32 of the 78 complaint allegations were substantiated resulting in deficiencies. Intake NC00191011 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag F695 at a scope and severity J. Immediate Jeopardy began on 08/26/22 and was removed on 09/17/22 Intake NC00192360 resulted in immediate jeopardy. Immediate Jeopardy was identified at:	F 000		

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F 000	Continued From page 3 CFR 483.45 at tag F760 at a scope and severity K. Immediate Jeopardy began on 06/26/22 and was removed on 09/17/22. Immediate Jeopardy was also identified at: CFR 483.10 at tag F580 at a scope and severity (K). Immediate Jeopardy began on 07/14/22 and was removed on 09/17/22. CFR 483.35 at tag F726 at a scope and severity (K). Immediate Jeopardy began on 08/26/22 and was removed on 09/17/22. The tags F695 and F760 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		11/2/22

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F 580	Continued From page 4 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interviews, the facility failed to notify the physician or nurse practitioner (NP) when antiseizure medication remained unavailable for Resident #140, pain medication was unavailable	F 580	F580 # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 580	Continued From page 5 for Resident #42, and when the nurse was unable to obtain intravenous (IV) access for Resident #111 to provide hydration as ordered for 3 of 4 residents reviewed for notifications (Resident #140, Resident #42, and Resident #111). Immediate jeopardy began on 7/14/22 when the physician was not notified the antiseizure medication continued to be unavailable and was not being administered. The facility failed to notify the physician of antiseizure medication not being administered as ordered for Resident #140. Immediate jeopardy was removed on 9/17/22 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put in place are effective. The facility was also cited at a scope and severity of "E" for example #2 (Resident #42) and example #3 (Resident #111). The findings included: 1. Resident #140 was admitted to the facility on 10/12/20. Diagnoses included epilepsy (seizure disorder) and Wernicke's encephalopathy (degenerative brain disorder). Resident #140 was initially ordered Vimpat (antiseizure medication) on 10/12/20. The order dated 5/27/22 revealed Vimpat 200 milligrams (MG) give 1 tablet by mouth two times a day for seizures, controlled substance.	F 580	practice; Resident #140 - Nurse Practitioner #1 was made aware of the missed medication on 9/14/22 during survey. Nurse Practitioner #2 was made aware of the missed medication for Resident #140 on 9/16/22 during survey. Physician #1 was made aware of the missed medication on 9/15/22 during survey. Resident #140 received Vimpat as ordered on 7/21/22, once the medication was made available via generic medication order/insurance authorization. Consultant reviewed the medication administration record on 10/7/22 and Resident #140 has received the Vimpat since the allegation of compliance on 9/17/22. Resident # 42 - Physician #1 was made aware of the missed doses on 9/15/22 and Nurse Practitioner was notified of the missed doses on 9/14/22 during survey. Consultant reviewed the medication administration record on 10/7/22 and Resident #42 has received her Salonpas pain patch as ordered since 9/17/22. Resident #111- The Provider was notified by nursing on 7/27/22 that IV access was unsuccessful and IV fluids were not administered. Nurse Practitioner #1 reviewed labs and assessed the resident on 7/27/22. The resident was sent out to the emergency room for further evaluation and treatment.	

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F 580	Continued From page 6 A nurse progress note dated 6/24/22 at 2:06 PM indicated there was a follow up with the neurologist's office for a replacement medication for Vimpat. It was noted the office would send new orders to the facility. A nurse medication administration note written by Nurse #10 dated 6/27/22 at 1:36 PM revealed Resident #140's Vimpat was unavailable, and the physician was aware. During an interview with Nurse #10 on 9/13/22 at 10:52 AM, she stated she did not notify the physician that Resident #140's antiseizure medication was unavailable. Nurse #10 stated Nurse #6 had notified the physician and the family representative. She stated resident #140 went without his Vimpat for "awhile" in June and July. Nurse #10 did not know exactly how long the resident was without the medication. A nurse medication administration note written by Nurse #23 dated 7/18/22 at 9:44 AM revealed Resident #140's Vimpat was unavailable, and the physician was aware. Review of controlled substance records revealed nurses administered Vimpat to Resident #140 until 6/26/22 when the medication became unavailable. The resident did not receive prescribed Vimpat from 6/26/22 - 7/9/22 or from 7/14/22 - 7/21/22. During an interview with Nurse #6 on 9/14/22 at 10:35 AM, she stated Resident #140 did not receive his Vimpat after the pharmacy could not refill it. Nurse #6 notified the NP who requested that staff contact the neurologist. Nurse #6 stated she did not know which nurse contacted the	F 580	# - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/15/22 The Assistant Director of Nursing (ADON) reviewed medication orders for all current residents receiving seizure medications to assure that medications were available. Compliance was noted (all residents had the prescribed amount of medication). On 10/10/22 the Director of Nursing, Assistant Administrator, Assistant Director of Nursing began reviewing all current resident□s medication administration record and treatment administration record to ensure all medications and treatments were administered as ordered. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 9/16/22 The Regional Director of Clinical Services, Vice President of Operations developed a protocol to reconcile medication orders with the pharmacy and to ensure residents received medications as ordered. The protocol includes: 1. receive clarification for a medication hold order, and/or 2. request alternative orders while original order is being processed or provided by pharmacy or while insurance	

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neurologist.

An interview was conducted with NP #1 on 9/14/22 at 10:45 AM. NP #1 stated she was notified in June 2022 that Resident #140's Vimpat was not available. NP #1 informed the staff Resident #140 could not go without Vimpat and could end up in the hospital. Administrator #2 assured NP #1 the medication would be obtained, and the facility could cover the cost if needed. NP #1 understood the medication would be provided and was unaware the Vimpat continued to not be administered in June and July.

An interview was conducted with Physician #1 on 9/15/22 at 10:19 AM. Physician #1 stated he was not aware Resident #140 did not receive Vimpat as ordered.

During an interview with NP #2 on 9/16/22 at 9:41 AM, she stated in June 2022 Nurse #6 informed her Resident #140's Vimpat was not available. NP #2 believed Nurse #6 spoke with the neurologist.

A follow up interview was conducted with NP #2 on 9/16/22 at 12:07 PM. NP #2 clarified she was made aware Resident #140 did not have his Vimpat in June 2022. She was not aware of the 3-day supply that was obtained 7/10/22 - 7/13/22 and was not aware the resident was again without the medication on 7/14/22 - 7/21/22 after the 3-day supply ran out.

An interview was conducted with the Neurologist on 9/16/22 at 12:37 PM. She stated the office was notified that insurance would not cover Vimpat for Resident #140. On 6/24/22, a facility nurse called and requested an alternate

authorization is being obtained.
3. Follow-up with the pharmacy to understand the cause of medication unavailability with immediate resolution.
4. Follow-up to internal provider (Physician and or Non-Physician Practitioner) if specialist office is not available immediately for follow-up orders.
5. Medication Aides will notify a Licensed Nurse if medications are not available, if alternative orders are needed, or clarification orders are needed for a medication hold order.
On 9/16/22, Education was provided on the protocol for notifying the Physician and/or Non Physician Practitioner when medications are not available by the Director of Nursing, or Staff Development Coordinator to all full time, part time, as needed, and contracted nursing staff (if applicable) on proper notification to providers, including Physician and NP, when a medication is unavailable. Staff not working on 9/16/22 will receive education prior to the start of their shift after 9/16/22.

On 10/6/22, the Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing and/or Clinical Consultant provided additional education on notifying the Physician and/or Non Physician Practitioner for additional instructions/orders when an order for IV hydration cannot be followed for reasons including, but not limited to, inability to obtain IV access, etc. The education was provided to all Licensed Nurses (full time, part time, as needed, and contract). Staff

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medication. A prescription for the generic form of Vimpat was sent to the facility. She was not aware of how long Resident #140 was without Vimpat. In July 2022, the resident's family member spoke with the office nurse and reported Resident #140 had not been receiving Vimpat at the facility.

The Administrator and Nurse Consultant were verbally notified of Immediate Jeopardy for F580 on 9/15/22 at 2:09 PM.

The facility provided a credible allegation of Immediate Jeopardy removal with a correction date of 9/17/22:

Removal Plan F580

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

Vimpat was not administered as ordered on 6/26/22 - 7/10/22 and from 7/14/22 - 7/21/22. The medication was ultimately made available via generic medication order/ insurance authorization and after 7/21/22, the patient has received the medication.

The MD and NP indicated Vimpat was a medication Resident #140 should not go without and he could have a seizure, end up in the hospital, and/or sustain serious harm as a result of a seizure. There was no harm or adverse effect on Resident #140. Resident was receiving other ordered seizure medications during the missed administrations of the Vimpat.

2. Specify the action the entity will take to alter

not working on 10/6/22 will receive education prior to the start of their shift.

This education will be added to the new hire orientation for all licensed Nursing Staff and Medication Aides.

- 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

The Director of Nursing, Assistant Director of Nursing, Nursing Supervisors, and/or Nurse Consultants will review the Medication Administration Records against the medication supplies for 25 residents weekly for 2 months and then at least 25 residents monthly for 4 months to ensure that medications are available and administered as ordered. When medications were not administered as ordered the chart will then be reviewed to determine if the Physician or Non Physician Practitioner was notified. The results of the audit will be documented on an audit tool entitled Medication Match-back Audit .

Results will be reviewed and discussed in the Quality Assurance Performance improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.

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F 580	Continued From page 9 the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete; The assistant director of nursing (ADON) reviewed medication orders for all current residents receiving seizure medications to assure that medications were available on 9/15/22. No other anti-seizure medications were unavailable. Education will be provided by 9/16/22, by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or designee to all full time, part time, as needed, and contracted nursing staff (if applicable) on proper notification to providers, including Physician and NP, when a medication is unavailable. The expectation would be to receive clarification for a medication hold order, and/or alternative orders. Staff not working on 9/16/22 will receive education prior to the start of their shift after 9/16/22. Alleged date of IJ removal is September 17th 2022. Person responsible for implementation is the administrator The credible allegation was validated on 9/16/22 when staff interviews revealed that they had received recent education on processes when medications were unavailable, pharmacy notifications, when to have an authorization form completed, and notifying the physician and nurse practitioner when medications were unavailable. Facility documentation revealed staff were educated on issues related to medication availability and notifications. Date of IJ removal 9/17/22	F 580	Date of completion : 11/2/2022	

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2. Resident #42 was readmitted to the facility on 6/15/21. Diagnoses included arthropathy (disease of joints) and polyosteoarthritis (joint pain and swelling).

Resident #42's care plan, created on 1/16/22 with a target date of 9/19/22, revealed a focus area for pain. An intervention was listed for providing medication as ordered.

Resident #42 was ordered an over-the-counter pain patch (Salonpas pain relief patch) on 5/25/22. It was to be applied to the left shoulder daily.

Resident #42's quarterly Minimum Data Set (MDS) dated 7/14/22 revealed the resident was cognitively intact. The MDS indicated the resident did not receive pain medication.

Nurse progress notes written by Nurse #12 dated 8/20/22 and 8/21/22 revealed Resident #42's Salonpas pain patch was unavailable.

The pain assessment was not completed on the medication administration record (MAR) for dayshift on 8/20/22 and 8/21/22. The pain level was documented as "0" on the MAR for nightshift on 8/20/22 and 8/21/22.

Attempts to interview Nurse #12 who did not administer Resident #42's Salonpas pain patch on 8/20/22 and 8/21/22 were unsuccessful.

During an interview with Nurse #6 on 9/14/22 at 10:35 AM, she stated she was aware the Salonpas patches were not administered on

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8/20/22 and 8/21/22. Nurse #6 asked Nurse #12 to get an order for an alternate medication. It was unknown if Nurse #12 called the physician.

An interview was conducted with Administrator #1 on 9/14/22 at 1:00 PM. She stated she was unaware Resident #42 did not receive pain patches on 8/20/22 and 8/21/22.

An interview was conducted with Nurse Practitioner (NP) #2 on 9/14/22 at 2:16 PM. NP #2 stated she was not notified that Resident #42 did not receive her pain patches.

During an interview with Physician #1 on 9/15/22 at 10:19 AM, he stated he was not notified Resident #42 did not receive her pain patches on 8/20/22 and 8/21/22.

During an interview with the Assistant Director of Nursing (ADON) on 9/15/22 at 2:41 PM, she confirmed Nurse #12 documented that the Salonpas patches were unavailable. There was no documentation that the physician was notified.

3. Resident #111 was admitted to the facility on 7/22/22 with diagnoses that included acute liver failure, chronic kidney failure, and congestive heart failure.

The Minimum Data Set readmission assessment dated 8/18/22 revealed Resident #111 was cognitively intact and required extensive assistance with activities of daily living. She was independent with eating.

Review of provider orders dated 7/26/22 revealed an order to infuse normal saline at 100 milliliters over 24 hours intravenously.

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The progress note dated 7/27/22 at 10:21 am revealed IV access was not successful and IV fluids were not administered. The nurse indicated she contacted the provider and received an order to send Resident #111 to the emergency room for acute kidney failure.

The progress note dated 7/27/22 at 11:20 am revealed Nurse Practitioner #1 reviewed laboratory results and assessed Resident #111 for acute kidney injury. Nurse Practitioner #1 indicated the order given on 7/26/22 to infuse IV fluid was not implemented by the night shift nurse on 7/26/22 and she failed to notify the on-call provider to get further recommendations for hydration. Nurse Practitioner #1 further indicated Resident #111 was sent to the hospital on 7/27/22 for large volume repletion for acute kidney injury.

On 9/12/22 at 9:46 am during an interview was conducted with Resident #111 she indicated she had access to adequate fluids.

On 9/16/22 at 1:54 pm during an interview with the interim Director of Nursing she revealed she expected the provider to be contacted when the nurse was unable to gain IV access to infuse fluids to Resident #111 as ordered. She indicated notification to the provider should not be delayed.

On 9/16/22 at 2:07 pm a telephone interview was conducted with the current provider, Nurse Practitioner #3. She indicated based on the clinical presentation and progress note the previous provider had written that the nurse should have contacted the provider to make them aware that she could not gain IV access to infuse fluids to obtain further instructions. Nurse

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F 580	Continued From page 13 Practitioner #3 further indicated if the provider had been notified promptly, alternate measures to infuse fluids and diagnostic tests could have been implemented to treat dehydration in the facility. On 9/16/22 at 4:20 pm a telephone interview was conducted with the former provider, Nurse Practitioner #1, who was employed when the IV fluids were ordered on 7/26/22. She indicated the nurse on duty on 7/27/22 should have notified her immediately when she could not gain IV access for Resident #111 to get further instructions. Nurse Practitioner #1 explained she did not believe that this caused Resident #111 to be hospitalized that day but the nurse failing to notify was an issue due to her diagnosis of chronic kidney failure. Nurse Practitioner #1 indicated she was not aware that IV access was not established until she assessed Resident #111 on 7/27/22. At that time the decision was made to send Resident #111 to the emergency room for further evaluation and treatment. An interview with the Medical Director was unsuccessful. On 9/16/22 at 11:30 am during an interview with Administrator #1 she revealed she expected nurses to notify the provider when there were difficulties following physician orders.	F 580		
F 641 SS=B	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		11/2/22

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F 641	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to accurately code wandering behavior, a prognosis of less than six months, pain medication, and activities of daily living on the Minimum Data Set (MDS) assessments for 4 of 40 residents (Residents #58, #64, #42 and #98) reviewed for MDS accuracy. Findings included: 1. Resident #58 was admitted to the facility on 7/14/22. Diagnosis included, in part, dementia. A nurse's note dated 7/16/22 stated, " ...Resident wanders throughout the hallway and in her room ..." The admission MDS assessment dated 7/20/22 indicated Resident #58 had no wandering behaviors. A joint interview was completed with MDS Nurse #2 and the Regional Director of Clinical Reimbursement on 9/13/22 at 2:43 PM. MDS Nurse #2 explained when she coded wandering behavior on the MDS, she reviewed nurse aide charting to determine if a resident exhibited any wandering behaviors during the look back period. She also reviewed nursing notes documentation for information that indicated behaviors of wandering. During the interview, the nurse's note from 7/16/22 was reviewed by MDS Nurse #2 and she indicated based on the information, she should have coded wandering on the MDS assessment. MDS Nurse #2 shared that Resident #58 ambulated independently, walked	F 641	F641 1. MDS for Resident #58 was modified to include wondering behaviors. MDS for Resident #64 was modified to include hospice services. MDS for Resident #42 was modified to include pain medication. MDS for Resident #98 was modified to include accurate coding of ADL(s). 2. MDS(s) completed for the last 30 days was reviewed to ensure the sections for residents with wondering behaviors, residents receiving hospice services, residents on pain medication and resident□s ADL(s) were coded correctly. Corrections were made as found. 3. Current MDS nurses educated by Regional Director of Reimbursement/designee regarding MDS accuracy including pacing and wandering as a behavior, making sure to check less than 6 months on hospice patients, capturing pain patch on MDS and accurately coding of Activities of Daily Living 4. Regional director of MDS or designee will audit 10% of MDS assessments for accuracy, weekly for 2 months and monthly for 4 months to ensure compliance. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting x 2 for further resolution if needed. Date of completion : 11/2/2022	

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around the facility, and paced, with no purposeful movement due to her confusion. The Regional Director of Clinical Reimbursement concurred that wandering behavior should have been coded on the MDS assessment.

2. Resident #64 was admitted to the facility on 4/24/17. Diagnosis included, in part, chronic obstructive pulmonary disease.

The medical record revealed Resident #64 was admitted to Hospice services on 6/16/20.

The quarterly MDS assessment dated 7/29/22 indicated the resident received Hospice services, but a prognosis of less than six months was not indicated.

During an interview with MDS Nurse #2 on 9/14/22 at 1:38 PM, she explained if a resident was coded on the MDS assessment as receiving Hospice services she also coded a life expectancy of less than six months. She confirmed Resident #64 received Hospice services and said she mistakenly had not checked the resident's life expectancy was less than six months. MDS Nurse #2 added it was an oversight.

3. Resident #42 was readmitted to the facility on 6/15/21. Diagnoses included arthropathy (disease of joints) and polyosteoarthritis (joint pain and swelling).

Resident #42 was ordered Salonpas pain relief patch on 5/25/22. It was to be applied to the left shoulder daily.

Resident #42's quarterly Minimum Data Set

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(MDS) dated 7/14/22 revealed the resident was cognitively intact. The MDS indicated the resident did not receive pain medication.

Observations of Resident #42 on 9/12/22 at 1:48 PM and 9/15/22 at 9:10 AM revealed she was wearing the Salonpas pain patch to her left shoulder.

An interview was conducted with MDS Nurse #1 on 9/16/22 at 11:26 AM. She stated she made an error in marking "no" in the MDS for Resident #42's pain regimen. Salonpas pain patches indicated the resident was on a pain regimen.

An interview was conducted with Administrator #1 on 9/16/22 at 2:57 PM. She stated the MDS should accurately reflect residents who were administered pain medications including Salonpas pain patches.

4. Resident #98 was admitted to the facility on 7/29/20 with diagnoses that included Dementia, Dysphagia and Peripheral Vascular Disease.

Review of the "Documentation Survey Report" (Activity of Daily Living (ADL) care tracker) for August 2022 revealed the documentation was incomplete. From August 1st to August 16th the resident was marked as independent for bed mobility, dressing, personal hygiene, toilet use, transferring, and walking in the room for most of the days that were documented.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 8/16/22. This assessment revealed Resident #98 was cognitively impaired with a Brief Interview for

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Mental Status (BIMS) score of 7 out of 15. No behaviors were reported. The assessment also indicated Resident #98 required supervision with set up assistance with bed mobility, transfer, walking in room and walking in the corridor, and limited assistance with dressing, personal hygiene, and toileting with 1-person physical assistance. The MDS assessment indicated Resident #98 was always incontinent of bladder and bowel.

During an observation on 9/15/22 at 11:19 AM, Resident #98 was observed to be walking independently in her room with a walker.

During an interview 9/16/22 at 8:25 AM, NA #1 indicated she was assigned to the resident. NA #1 stated the resident was independent with walking (uses a walker), transfer, toileting, dressing, personal hygiene and eating. The resident needed set up assistance only.

During an interview on 9/15/22 at 1:32 PM, Nurse #26 stated the resident was alert and oriented and can verbalize her needs. Nurse further stated the resident was independent with most of her ADL's and has not had any change in medical condition or decline in her ADL's. The resident needed minimum assistance and was able to walk independently with the walker in the facility.

The facility provided the list of staff assigned to the resident during the look back period based on the POC documentations.

During a telephone interview on 9/16/22 at 10:38 AM, NA #13 indicated she was agency staff and worked from 7 AM- 7 PM. NA #13 indicated she was working in August (unsure of the exact days)

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and was assigned to the resident. NA stated Resident #98 was independent with walking (uses walker), not a high risk for falls, independent with most ADL's including toiletings, dressing, bed baths, personal hygiene etc. Resident very active, alert, and oriented and could verbalize her needs.

During a telephone interview on 9/16/22 at 10:50 AM, NA #15 stated she was assigned to the resident in August and worked 7 AM - 7 PM shift. NA #15 stated during her care the resident was independent with ADL care. The resident could go to toilet, move around in her walker, could dress self and communicate her needs. The resident did not need assistance except for set up help.

During a telephone interview on 9/16/22 at 11:20 AM, NA #14 indicated she was agency staff and worked 7 AM -7 PM. NA #14 stated she was working with the resident in August, but unsure of the dates. NA indicated the resident was alert and oriented, could communicate her needs, was able to bath, wash herself, dress, and was independent with most of her ADL activities. She indicated the resident could walk without assistance in the room and in the hallway with her walker and walked around the facility.

During a telephone interview on 9/16/22 at 11:30 AM, NA #16 stated she was working with the resident in August (unsure of the dates). NA #16 further stated Resident #98 was alert and oriented, independent with her ADL's and could use the toilet, could dress, complete personal hygiene without any assistance. The resident walked without any issue with her walker.

During an interview on 9/14/22 at 12:55 PM, Nurse Practitioner (NP) #2 indicated the resident

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F 641	Continued From page 19 had diagnoses of Cerebrovascular accident (CVA), Dementia and was very hard at hearing, and using hearing aids had little effect on her hearing. The resident functional capacity was assessed as needing minor assistance. The resident could self-feed and ambulate without any assistance. NP indicated she was following the resident on regular basis, and the resident was medically stable. There was no decline in her functional capabilities. During an interview on 9/16/22 at 9:12 AM, the MDS coordinator stated prior to completing section G (ADL) on MDS, she would interview the aides, nurse, therapy staff and other staff who were assigned to the resident. She stated she had interviews staff assigned to the resident from both shifts which included agency staff. She indicated there was some ADL care documentation issue and hence just saw the last 2 days of POC documentation instead of the 7 day look back period. MDS coordinator indicated the MDS assessment was also based on her observation and during her observation, she had to place her hand behind the resident when ambulating. During an interview on 9/16/22 at 2:33 PM the Administrator stated it was expected that all ADL documentations were completed and accurate. MDS should document all care recorded. The Administrator further stated resident's MDS assessments should reflect current status of the resident.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		11/2/22

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F 677	Continued From page 20 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with resident and staff, the facility failed to provide incontinence care (Resident#75) and failed to provide personal hygiene and grooming (Resident #355) for 2 of 15 dependent residents reviewed for activities of daily living (ADL) care. The findings included: 1.Resident #75 was admitted to the facility on 4/19/22 The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 8/5/22. This assessment revealed Resident #75 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. No behaviors were reported. The assessment also indicated Resident #75 required extensive assistance with bed mobility and total dependence with dressing, personal hygiene, and toileting with 1-person physical assistance. The MDS assessment indicated Resident #75 was always incontinent of bladder and bowel. Resident # 75 ' s current care plan addressed a problem related to Activity of Daily living (ADL) self-care performance deficit related to limited range of motion (ROM) (Last Reviewed/Revised on 8/25/22). The planned interventions indicated the resident was extensive assistance for toileting. On 9/12/22 at 11:20 AM an interview was	F 677	F677 1. Incontinence care has been provided for Resident 75. Hygiene and grooming has been provided to Resident 355 2. Current residents in the center who are dependent on ADL care have the potential to be affected. 3. Current clinical staff will be educated by the Director of Nursing/designee on Activities of Daily Living for dependent residents, including timely incontinence care and grooming and hygiene including brushing and combing hair to prevent tangles and washing hair on shower days Any nursing assistant who is not educated will not be allowed to work until education received Any new nursing assistant will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process 4. DON or designee will audit for incontinence care and grooming/hygiene needs at the following intervals: 25 residents weekly for 2 months and then at least 25 residents monthly for 4 months to ensure compliance. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting for further resolution if needed. Date of completion : 11/2/2022	

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conducted with Resident #75. He stated he had not received any personal care today on day shift. The NA brought him his breakfast and that was the only time he had seen staff. He stated he was wet, and his linen was wet. He further stated that this was not the first time he had not received personal care in the morning. He stated his skin on his backside was beginning to hurt from being wet.

On 9/12/22 at 11:30 AM an interview was conducted with Nurse Aide (NA) #1. She stated that she had not provided care to Resident #75 today on day shift. She indicated her shift started at 7:00 AM. She stated the resident was alert and oriented and could verbalize his needs. She stated she thought the agency NA had provided care to the resident this morning. She stated she could provide care now when requested.

During an observation on 9/12/22 at 11:40 AM, NA #1 provided a bed bath and incontinence care to Resident #75. The resident's linen was wet with urine that had a strong odor all the way through to the mattress. The undergarment was soaked through with urine. The NA#1 wiped the mattress with a dry towel. The mattress was not cleaned of the visible urine with soap. The linen was changed. The resident also had a bowel movement. His skin was intact. Interview with NA #1, she stated the resident had not received personal care yet this morning because "I was assisting other residents.". A lingering odor of urine was detected in the room at the time of this interview and observation.

On 9/12/22 at 11:45 AM an interview was conducted with Nurse #1, who indicated the resident was a heavy wetter and incontinent care

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should be completed every 2 hours by the nurse aides. Nurse indicated she was unsure if another NA who was agency staff provided care to the resident.

On 9/12/22 at 12:30 PM an interview was conducted with agency NA. NA #5 stated she was not assigned to the resident and had not provided incontinent care to the resident since morning. NA #5 stated when she was assigned to the resident, the resident had to be changed every 2 hours as he was a heavy wetter.

An interview was conducted on 9/15/22 at 2:20 PM with the facility's Administrator. During the interview, the Administrator stated she would expect staff to address a resident ' s concern immediately when a call light was activated and for ADL care to be provided upon any request for incontinence care. Administrator further stated that routine checks with rounding should be conducted every two hours if the resident had not called out requesting assistance before that.
2. Resident #355 was admitted to the facility on 8/10/22 with diagnoses that included surgical procedure for right shoulder dislocation.

The admission Minimum Data Set assessment dated 8/16/22 revealed Resident #355 was cognitively intact and required extensive assistance for personal hygiene needs. She was totally dependent for all activities of daily living. She had functional impairment on one side of the upper extremity.

The care plan dated 8/10/22 revealed Resident #355 was admitted for rehabilitation services due to a recent displaced fracture and dislocation of the right shoulder due to a fall at home.

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An interview and observation with Resident #355 were conducted on 9/12/22 at 10:15 am. She revealed staff had washed her hair earlier that morning around 5:00 am but her hair was not dried or combed yet. Her hair was loosely wrapped in a bath towel while lying in bed. She was able to comb her hair but needed staff to assist due to the length and right arm impairment. Upon further observation, Resident #355's hair appeared very oily and tangled. Her hair was long and was below shoulder length. She indicated she desired for staff to comb her hair daily and after washed but it was not being done. She indicated she didn't know why staff left the bath towel wrapped on her hair after it was washed. Resident #355 further indicated this contributed to her hair being matted and tangled since admission to the facility.

On 9/12/22 at 11:55 am on a return visit with Resident #355 the bath towel was observed still loosely wrapped on her hair.

On 9/12/22 at 12:36 pm an interview was conducted with Nurse Assistant (NA) #4 who was assigned to Resident #355 during the 7:00 am to 7:00 pm shift that day. NA #4 revealed that he was told staff had provided a bed bath to Resident #355 earlier in the morning on the previous shift, but he gave her another bed bath at approximately 11:00 am because she requested one. NA #4 indicated he had left the bath towel in Resident #355's hair after he provided a bed bath because she asked for it to be left on. NA #4 indicated he had not yet combed Resident #355's hair but would do it later in his shift.

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ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

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F 677	Continued From page 24 On 9/14/22 at 1:44 pm an interview was conducted with Unit Supervisor #1. She indicated Resident #355 required moderate to extensive assistance with hygiene and grooming needs. She was not aware that staff had left a bath towel on Resident #355's hair and left uncombed after washing on 9/12/22. Unit Supervisor #1 indicated Resident #355's hair was prone to oiliness and staff washed her hair on her shower days every Tuesday, Thursday, and Saturday on day shift. On 9/16/22 at 11:30 am during an interview with the interim Administrator, she indicated she expected nursing staff to provide Resident #355 with hygiene and grooming needs daily and as needed. She explained that staff were expected to comb or brush Resident #355's hair at least once a day to prevent tangles and matting. Resident #355's hair was also to be washed on her scheduled shower days and on other days as needed.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		11/2/22

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F 686	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of staff and resident, the facility failed to follow the pressure ulcer dressing order and used saline instead of wound cleanser and placed the wrong medication in the wound bed (Resident #131) for 1 of 3 residents reviewed for pressure ulcer. Findings included: Resident #131 was admitted to the facility on 12/8/20 with pressure ulcer of his sacral region stage 4. Resident #131 ' s quarterly Minimum Data Set dated 8/31/22 documented stage four stage 4 pressure ulcers that were present on admission. Resident #131 ' s care plan dated 6/21/22 documented pressure ulcer to right lower leg and sacrum provide care as ordered. Resident #131 ' s physician order pressure ulcer dressing dated 9/7/22 documented dressing change to the sacrum cleanse with wound cleanser, apply collagen sheet (wound bed) and cover with foam border dressing and dressing change to the right lower leg cleanse with wound cleanser, apply collagen sheet (wound bed), and cover with foam border dressing. On 9/13/22 at 6:40 am an observation was done of Resident #131's sacral and right lower leg pressure ulcer care by Nurse #3. She cleansed the wounds with sterile saline, placed calcium alginate in the sacral and right leg ulcer wound bed, and covered with foam dressing. The wounds were clean with fresh granulation tissue.	F 686	F686 1. Resident # 131 is now receiving wound care as per MD orders. Medical Provider was notified at time of incorrect treatment completed with no new orders obtained. 2. Current residents in the center receiving wound care have the potential to be affected. 3. Current Licensed Nurses will be educated by the Director of Nursing/designee on following doctor orders when providing wound care. Any licensed nurse who is not educated will not be allowed to work until education is received. Any new licensed nurse will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process. 4. DON or designee will audit 5 residents weekly for treatments for 2 months and then at least 5 residents monthly for 4 months to ensure compliance. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Date of completion : 11/2/2022	

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F 686	Continued From page 26 There were no signs of infection. Nurse #3 opened the resident ' s electronic medical record for the pressure ulcer orders and the orders documented cleanse with wound cleanser, place a collagen sheet, and cover with foam border dressing for the sacral and right leg. On 9/13/22 at 7:05 am an interview was conducted with Nurse #3. Nurse #3 stated she cleansed the wound with sterile saline because there was no wound cleanser available to use and she placed calcium alginate to the sacrum and right lateral lower leg pressure ulcer and not a collagen sheet because she thought the order was for calcium alginate. She stated she should have followed the order. On 9/13/22 at 10:40 am the Director of Nursing was informed of Resident #131 ' s dressing change was completed incorrect.	F 686		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview of the staff, physician, Respiratory Therapist, and resident, the facility failed to provide necessary respiratory care and services	F 695	F695 Respiratory Care # 1 - Address how corrective action will be accomplished for those residents found to	11/2/22

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F 695	Continued From page 27 that met the need for Resident #46 to maintain a clear airway from tracheal secretions and frequent coughing which resulted in five trips in a two- and one-half week period of time to the Emergency Department (ED) to clear her airway and treat hypoxia. The facility failed to seek medical attention for Resident #505 when he complained of shortness of breath earlier in the night which resulted in low oxygen of 50% (out of 100%) by early morning. Emergency medical services were required, and a non-rebreather oxygen mask (high level oxygen flow) was needed and treatment at the Emergency Department. Resident #505 was also sent to an outside cardiology appointment without oxygen and was in respiratory distress for 2 of 2 residents reviewed for respiratory care. Immediate jeopardy began on 8/26/22 for Resident #46 when staff had not provided the necessary respiratory care and services and the resident had to be sent to the ED for tracheal tube obstruction, large amounts of secretions, and loss of her tracheostomy tube. Immediate jeopardy began on 7/5/22 for Resident #505 when staff failed to seek medical attending when he complained of shortness of breath which began early in the night, was not addressed, and became acute by morning. Immediate jeopardy was removed on 9/17/22 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of an "E" which is no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure continued staff education and monitoring. Findings included:	F 695	have been affected by the deficient practice; On 7/5/22, nursing applied oxygen via nasal cannula at 8L on resident #505, Emergency Medical Services were contacted. Oxygen saturation levels were noted to come up to 84%. Emergency medical services applied a non-rebreather oxygen mask (high level oxygen flow) when they arrived. Resident was transferred to the Emergency room for further evaluation and treatment. Emergency room notes state with non-rebreather oxygen mask, resident #505 saturation levels increased to 90%. Resident returned to the facility later on 7/5/22 with no new orders. The Cardiology Nurse reports on 7/11/22 that resident #505 was provided 4 Liters of oxygen by nasal cannula and recovered in 20 minutes (repeat saturations increased to 98%). On 7/11/22, the facility took a full oxygen tank to the Cardiology Office for the resident to return with. Resident #505 discharged on 7/26/22. Resident #46 was assessed by the Director of Nursing on 9/15/22 and noted stable respiratory status. New orders were implemented between 9/13- 9/14/22 to include suctioning every four hours, and tracheostomy care every 12 hours and as needed. On 9/15/22, The Director of Nursing verified the new orders were being implemented as ordered, the new orders were validated to be present on the	

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F 695	Continued From page 28 1. A review of Resident #46 ' s record documented she was admitted to the facility on 7/12/22 with the diagnosis of acute respiratory failure. Admission history documented the resident required ventilation and was weaned off in the hospital. The resident was admitted to the facility for tracheostomy tube management. She was able to ambulate on room air with the tracheostomy tube in place during the day and required oxygen at night. Resident #46 ' s care plan dated 7/12/22 documented a focus for tracheostomy care and the interventions were an oxygen setting at 2 liters per minute and suction as necessary. Resident #46 ' s admission Minimum Data Set (MDS) dated 7/18/22 documented the resident had an intact cognition and no refusal of care. Resident #46 had multiple active diagnoses which included traumatic brain injury and respiratory failure. Treatments included oxygen therapy and tracheostomy care and suctioning. Resident #46 ' s physician orders were as follows: · Dated 7/12/22 humified oxygen 2 liters to the tracheostomy. · Dated 7/12/22 monitor the oxygen saturation every day and night shift. · Dated 7/12/22 suction excess secretions as needed. · Dated 7/12/22 tracheostomy care every shift and as needed. Clean or change the inner cannula as applicable. Specify inner cannula size 6. Review of Resident #46 ' s Treatment	F 695	Treatment Administration Record for the ordered frequency, and the Director of Nursing also verified the respiratory equipment was functioning correctly. The MDS Nurse updated Resident #46□s care plan on 9/16/22 to include the following aspects of tracheostomy care: securing trach ties, assessment and monitoring, oxygen settings, suctioning as ordered, and trach care. A respiratory therapist evaluated resident #46 on 9/16/22 and orders were updated as needed to include suctioning documentation related to amount, consistency, color and odor, and documented through/in the supplemental documentation attached to the treatment administration record. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with ordered respiratory therapy treatment could potentially be affected. 9/16/22 - The Director of Nursing reviewed a list of residents currently residing in the facility and found there were no other residents with a tracheostomy that would require tracheostomy care. 9/16/22 - The current census was reviewed by the Director of Nursing during survey and there were 7- residents with	

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F 695	Continued From page 29 Administration Record (TAR) documented the following for tracheostomy care: · There were no nursing initials for year 2022 dates 8/5, 8/12-14, 8/28-31 day shift. · There were no nursing initials for year 2022 dates 8/2-5, 8/9 and 10, 8/12, 8/15, 8/17, 8/21-23-, 8/25, and 8/29 night shift. · There were no nursing initials for year 2022 dates 9/8, 9/10 - 9/12 dayshift. · There were no nursing initials for year 2022 dates 9/4 night shift. On 9/13/22 at 3:15 pm an interview was conducted with the Medical Director (MD) The MD clarified his order for tracheostomy care each shift meant every twelve hours (nursing had 12 hours shifts) and included suctioning the resident at least once a shift, but this is not how the order was written on 7/12/22. It also was not described that way in the policy. There was also an order for suctioning as needed. On 9/13/22 at 3:15 pm an interview was conducted with Unit Supervisor #1. She stated she was not aware the physician expected nursing staff to suction Resident #46 each shift with the tracheostomy care. She stated she was aware there was an order for tracheostomy suctioning as needed but was not aware there were no nursing initials documenting suctioning had been provided for the month of August 2022 and September 1 through 13 2022. She stated that nursing staff were responsible for all respiratory care including the equipment, there was no Respiratory Therapist. Review of Resident #46 ' s TAR documented the following for suction tracheostomy as needed. No nursing initials for the month of August and	F 695	either a bi-pap/c-pap therapies and 26 residents on oxygen therapy. Personalized care plans were developed by the Assessment Nurses for residents with bi-pap, c-pap and oxygen therapies to include required aspects such as supplemental oxygen, transportation with oxygen, and application of oxygen to a CPAP/BiPAP. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Facility contracted with respiratory therapist on 9/16/2022 Current nursing leadership to include Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) received education with return demonstration on 9/16/22 by the center respiratory therapist regarding trach care to include: tracheostomy care, frequency of suctioning and reassessment of resident□s oxygen status and need for re-suctioning, respiratory assessment, and documentation of such care, as well as caring for patients with c-paps, bi-paps, and oxygen while in center and preparing for external appointments. In turn, nurse leadership (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator) provided full time, part time, as needed, and contracted nursing staff (agency) the same education with return demonstration	

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On 9/14/22 at 9:15 an interview was conducted with Unit Supervisor #1. She reviewed the treatment record for Resident #46 and was not aware there was no nursing initials for tracheostomy care documented and would identify the nursing staff for interview.

On 8/26/22, a nurse ' s note was documented by Nurse #6. Resident #46 had a change of condition due to an obstructed tracheostomy tube. The resident ' s oxygen level was 95% out of 100%, pulse was 80, and respirations were 19. The Nurse Practitioner (NP) was called and gave orders to send the resident to the ED. The TAR for 8/26/22 was not initialed for as needed suctioning.

On 9/14/22 at 11:40 an interview was conducted with Nurse #6. She stated, "I was assigned to Resident #46 on 8/26/22. I was not able to pass the suction catheter and suction the resident." She said she typically suctioned when she completed tracheostomy care. She stated, "I do not document the suctioning. I initial the tracheostomy care order on the Treatment Administration Record." Nurse #6 stated that she participated in a tracheostomy in-service when Resident #46 was first admitted. Nurse #6 stated she did not listen to the resident ' s lungs. Nurse #6 stated this was her first tracheostomy care resident.

The Emergency Department (ED) record dated 8/26/22 documented Resident #46 was seen for tracheal tube obstruction. The facility informed the ED that they were unable to suction the resident. No inner cannula was in place from the

on 9/16/22. Any staff assigned to a tracheostomy patient or patient with oxygen therapies will receive this education prior to the beginning of their shift, if not available on 9/16/22.

On 9/26/22 The Administrator, Director of Nursing, and Regional Director of Clinical Services conducted an in-depth analysis of the mechanisms, policies, training of nursing staff relative to Respiratory Care and determined the following would continue to be implemented: Education and training on Respiratory Care which includes: Tracheostomy care, Tracheostomy suctioning, respiratory assessment and documentation of such care, and caring to residents with CPAP, BIPAP, and Oxygen while in the facility and preparing for external appointments. In the event there is a concern during ordered tracheostomy care such as the staff member cannot effectively suction the tracheostomy and/or the tracheal tube becomes dislodged, the physician and/or Non Physician Practitioner will be notified for further follow up. This notification and any new instructions/orders will be documented in the resident□s medical record.

This education will continue to be provided to all newly hired staff during Facility Orientation as well as annual clinical competencies. The facility will continue to require any Staffing Agency used provide validation that Respiratory Care Training has been validated on all their licensed nurses prior to them

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facility, and one was placed in the ED. The Respiratory Therapist (RT) was unable to pass a suction catheter because of secretions and mucous accumulation and hardening causing a partial obstruction. The ear nose and throat (ENT) physician changed the tracheostomy tube. The resident was observed for two- and one-half hours and returned to the facility.

On 9/16/22 at 12:30 pm an interview was conducted with the facility contracted Respiratory Therapist (RT) hired on 9/16/22. She stated that the tracheostomy collar mist device (provides humidification to the tracheostomy) was not properly set up and was not misting as intended for an unknown period. Secretions can become dry and occlude when humidification was not provided. Occlusion can cause hypoxia and an inability to pass the suction catheter.

On 8/30/22 a nurses ' note was documented Resident #46 coughed, and her tracheostomy tube came out (it was not noted if the inner cannula was in place). All efforts to replace the tracheostomy by staff were not successful. Emergency Medical Services (EMS) were contacted, and the resident was taken to the emergency room.

On 9/16/22 at 12:30 pm an interview was conducted with the facility contracted Respiratory Therapist (RT) hired on 9/16/22. She stated that nursing should not replace a tracheostomy tube because they were not trained to properly perform this. She stated that EMS should be called. She stated that the resident should be suctioned as needed to clear the rhonchi and cough. Cough can contribute to loss of the tracheostomy tube. She stated repeated loss of a tracheostomy tube

working at the facility. The Director of Nursing and/or designee will be responsible for validating staff are competent in Respiratory Care.

- 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

The Director of Nursing, Assistant Director of Nursing and/or Nurse Consultants will monitor tracheostomy care, CPAP, BIPAP, Oxygen administration and care through direct observation, nursing documentation and nursing interviews at least 2 times each week for one month, then weekly for one month. Thereafter the monitoring will be completed monthly for at least 4 months. Results will be recorded on an audit tool titled Respiratory Care. Results will be reported to the Quality Assurance Performance Committee monthly by the Director of Nursing and results reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.

The Director of Nursing, Assistant Director of Nursing, and/or Nurse Consultants will review the orientation material for all newly hired licensed nurses to assure Respiratory Care Training with return demonstration was provided and clinical competency met. This will be accomplished for any

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F 695	Continued From page 32 was not usual. Resident #46 ' s Treatment Administration Record had no documentation that she had tracheostomy care on 8/28/22 through 8/31/22 day shift and 8/29 night shift. There was no documentation that she had tracheostomy suctioning as needed for all of August 2022. The ED note dated 8/30/22 documented Resident #46 was seen and diagnosed with tracheostomy tube change and aspiration pneumonia of the left lung. The resident required suctioning by the RT and the cough improved. Antibiotics were ordered. The resident was suctioned, tracheostomy tube was changed, and she returned to the facility. The resident maintained her oxygen level with use of oxygen while in the ED. Resident #46 had a physician order dated 8/30/22 for Augmentin (an antibiotic) suspension every 12 hours for 7 days for aspiration pneumonia written by the nurse practitioner. Resident #46 had no nurses ' note documented for the ED visit of 9/4/22. The ED note dated 9/4/22 documented Resident #46 was seen for dried secretions and tracheostomy change due to secretion accumulation. The inner cannula was not present when the resident arrived at the ED and the Ear Nose and Throat (ENT) Physician recommended the resident have a disposable inner cannula in place at all times to prevent crust and secretion accumulation. The resident was suctioned of a large amount of secretions. The resident reported to the ED Staff the tracheostomy was dislodged due to coughing secretions and she was feeling	F 695	contracted agency nurses by reviewing their competency validation list completed by the staffing agency when hired. This monitoring will be completed weekly for four weeks and monthly for 6 months. Date of completion : 11/2/2022	

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short of breath. The resident had increased work of breathing and oxygen was provided at the ED until the tube was changed.

On 9/9/22 Nurse #1 documented a nurses ' note. Resident #46 came out into the hall with her tracheostomy in her hand. She had coughed the tracheostomy out and staff was unable to replace. The resident was sent to the ED. No oxygen level was documented in this nurses ' note. Nurse #1 was not available for interview.

Resident #46 ' s ED documentation dated 9/9/22 indicated ENT had inserted a size 4 (smaller) tracheostomy cannula in place of the size 6 tracheostomy cannula that was dislodged due to coughing and lodged secretions. The resident received oxygen to increase her oxygen level from 90% to 98%. The ED physician was unable to place a size 6. The facility reported to ED staff they were unable to suction the resident at the facility due to thick, dry secretions. The hospital documented discharge instructions to change the inner cannula every 12 hours and to suction the tracheostomy every 4 hours to prevent clogging. An order was provided to follow up with ENT to be evaluated to have a surgical procedure to enlarge the tracheostomy again.

Review of Resident #46 ' s record did not reveal a new order for suction every 4 hours and to keep the inner cannula in place after the 9/9/22 ED visit. An order for ENT consultation was received by the facility.
A review of Resident #46 ' s record revealed a physician order to suction the tracheostomy tube dated 9/13/22 every 4 hours after the missed discharge order was found in the hospital discharge summary record dated 9/9/22.

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On 9/14/22 at 12:30 pm an interview was conducted with Unit Supervisor #1. She stated that the facility was not aware that Resident #46 had an ED discharge order dated 9/9/22 to suction every 4 hours. The facility had received an order for ENT consultation.

Resident #46 ' s nurses ' note dated 9/12/22 documented that the resident complained about not being able to breathe. The resident was suctioned a few times. There was no documentation of what was obtained. Oxygen reading was 88% out of 100% and heart rate was 133. The Nurse Practitioner was called and provided an order to send the resident out to the ED.

Resident #46 ' s ED note dated 9/12/22 documented the resident was unable to breathe due to secretions. The resident had secretions that the facility, reportedly, was not able to suction and clear without significant relief. EMS documented resident was hypoxic (low in oxygen) in the high 80s oxygen reading (out of 100). The resident had increased work of breathing. with oxygen saturation of 90% on room air. The diagnosis was clogged tracheostomy tube with thick clear secretions that the hospital RT had to clear. Coarse rhonchi were cleared after suctioning. The oxygen saturation was 96% on room air after suctioning. The chest x-ray had no acute findings. The resident was stable for discharge back to the facility.

On 9/13/22 at 10:00 am an interview was conducted with Nurse #2. Nurse #2 stated she completed tracheostomy care and asked the resident if she wanted to be suctioned and she

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said, "No."

On 9/13/22 at 11:50 am an interview was conducted with Resident #46. The resident nodded "no" to whether she was suctioned with her tracheostomy care this morning and nodded "no" that she had not refused.

On 9/13/22 at 11:55 an interview was conducted with Nurse #2. She stated she was assigned to the resident on 9/13/22. She reviewed the resident ' s electronic chart to confirm the resident had tracheostomy care each 12-hour shift and was suctioned as needed (the new order for every 4 hours had not been entered yet). She stated she only suctioned the resident when the resident requested to be suctioned. She stated she does not document the suctioning other than placing her initials on the Treatment Administration Record for tracheostomy care. If there were no initials on the TAR, then suctioning was not completed or needed. She does not document what was obtained, if the inner cannula was cleaned or changed, and how the resident tolerated the procedure. She stated she was not aware that the resident's oxygen concentrator was set to 5 liters this morning at 9:00 am when the resident was sleeping. She stated she provided tracheostomy care earlier in the morning. She stated the night shift nurses set the concentrator setting when the resident goes to bed. The resident usually had not used oxygen when she was up, only while sleeping. She stated she was not familiar with the resident's oxygen order for her humidified tracheostomy collar. She stated she was not aware the hospital had sent the discharge instructions to suction the resident every 4 hours and to change the inner cannula every 12 hours.

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On 9/13/22 at 3:20 pm an observation was done of Resident #46 in the therapy room. The resident had an audible rhonchi (gurgling of mucous) when breathing. The resident was interviewed. The resident nodded, "yes," that she would have a suctioning and needed to be suctioned. The resident nodded "no" that she had not refused suction today.

On 9/13/22 at 3:30 pm an interview was conducted with the Medical Director (MD). The MD stated that he was not aware Resident #46 was seen in the Emergency Department (ED) 4 times in the last 3 weeks due to a mucous-plugged or loss of her tracheostomy tube. The staff had called the Nurse Practitioner and she had addressed the concerns by sending the resident to the ED. A stable tracheostomy would not need to be sent to the ED for this frequency. The MD stated Resident #46's tracheostomy was no longer stable. The MD was not aware the hospital sent discharge instructions for Resident #46 for nursing to change the tracheostomy inner cannula every 12 hours and to suction every 4 hours after the third trip to the ED. The MD stated he had a discussion with corporate staff and administration that there were concerns with nurse staffing and care provided.

Resident #46 ' s physician orders were as follows:

9/13/22 tracheostomy care every 12 hours and as needed. Change inner cannula as applicable (size at the time of care). Specify inner cannula size 4.

9/13/22 suction resident every 4 hours at 12 am, 4 am, 8 am, 12 pm, 4 pm, and 8 pm.

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9/13/22 oxygen 2 liters per minute via tracheostomy collar when sleeping.

On 9/13/22 at 3:50 pm an interview was conducted with Resident #46. Nursing staff was ready to suction the resident and she asked about the suctioning and was informed that the physician had a concern about the secretions and would like for the resident to be suctioned at least once a shift (12 hours). The resident agreed to be suctioned. (The timeframe was before the facility followed up on the new order suction every 4 hours which was missed on 9/9/22.)

On 9/14/22 at 5:50 am an observation was done of Resident #46. She was sleeping in her bed with the head of the bed elevated approximately 30 degrees. The resident's tracheostomy dressing was clean and dry. Her mist collar was in place but was dry and not misting. The oxygen concentrator was set to 2 liters as ordered this observation.

On 9/14/22 at 8:10 am an observation was done of Resident #46 with assigned Nurse #4. The resident was ambulating in her room and not wearing the mist collar. The collar was sitting on the humidification device, and it was not misting. The resident coughed and rhonchi were audible, and she was holding her tracheostomy in place. Interview with Resident #4, she stated the mist collar was "dry." Nurse #4 was interviewed concurrently and stated she was not aware the mist collar was not working, and the resident had new orders to suction every 4 hours.

On 9/14/22 at 9:15 am an interview was conducted with Unit Supervisor #1. Unit

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Supervisor #1 stated she was not informed or aware that Resident #46's humidification for the tracheostomy collar was not working. Unit Supervisor #1 stated nursing was responsible to check the respiratory equipment and inform her or management when there were issues. Unit Supervisor #1 stated she would call the vendor to check the resident's humidifier equipment.

On 9/14/22 at 2:30 an interview was conducted with US #1. She stated that Resident #46 ' s misting device was turned off. The equipment was operating as intended when turned on.

On 9/16/22 at 12:30 pm an interview was conducted with the facility contracted Respiratory Therapist (RT). The RT stated she checked the mist/humification on 9/16/22 for Resident #46 and it was not set up correctly and operating as intended.

On 9/14/22 at 9:15 am an interview was conducted with the Corporate Nurse Consultant and Interim Administrator. The Corporate Nurse Consultant stated the physician order for suctioning every 4 hours for Resident #46 was received yesterday (9/13/22) from the physician. The Corporate Nurse Consultant stated the tracheostomy care policy did not include tracheostomy suction as part of the care. Corporate Nurse Consultant stated there was an order to suction as needed. The Corporate Nurse Consultant and Administrator stated they were not aware there were no nurse initials signed for the months of August 2022 and September 1 through 13 on the resident's TAR for tracheostomy suctioning. The Corporate Nurse Consultant and Administrator stated they were not aware there were no nurse initials signed on the

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TAR for tracheostomy care for several occasions both shifts during the month of August 2022 and September 5 through 13, 2022 on occasions for both shifts. The Corporate Nurse Consultant and Administrator stated they were not aware of the hospital discharge summary order for the resident's inner tracheostomy cannula to be changed every shift and to suction the resident every 4 hours dated 9/9/22. This was missed. The Corporate Nurse Consultant and Administrator stated they were not aware the Medical Director felt the hospital discharge instruction to increase suctioning to every 4 hours and a needed procedures to make the tracheostomy larger made the resident's tracheostomy unstable.

A review of Resident #46 ' s ENT office visit dated 9/16/22 documented the resident was seen for a return visit (last visit date unknown). The resident had difficulty speaking due to tracheostomy. She had a copious amount of oral and pharynx (voice box) secretions. Her tracheostomy was well seated. There were no signs of infection. The tracheostomy was stable. There were two problems: (1) paralysis of the vocal cords and (2) a very high risk for aspiration.

On 9/14/22 at 5:40 am an interview with Nurse #3. She stated she worked here 2 months and was agency staff. She provided Resident #46 tracheostomy care each shift when she worked which included suctioning. She reused the catheter which was stored in its original packaging on her shift and then discarded it. The facility had not provided education for tracheostomy care and/or suctioning. She stated the order just changed this shift to provide suctioning every 4 hours. She stated the resident

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needed frequent tracheostomy tube change, not just the inner cannula because she had a large amount of secretions that got stuck to the cannula. She stated she had a concern that the mist collar was not moist this shift, it appeared dry. There was no mist observed. She stated this concern was not reported to management. She stated she was not aware the resident had gone to the hospital on 4 occasions for a mucous plugged tracheostomy tube and/or tube dislodgement and was not aware that the resident's tracheotomy (opening) had gotten small and would require a surgical procedure to widen the opening. She stated there were replacement tracheostomy inner cannulas in the resident's bedside nightstand.

B. Resident #46 ' s physician order dated 7/12/22 was for oxygen therapy 2 liters into the tracheostomy collar tubing.

On 09/13/22 at 9:58 am an observation was done of Resident #46. The resident was in her bed sleeping with the tracheostomy collar in place. The collar had a tube approximately 24 to 30 inches that was attached to a sterile water misting device for humidification. The tracheostomy had a velcro tie around the neck holding the tracheostomy in place. The oxygen concentrator at the bedside was set to 5 liters attached to the tracheostomy collar tubing. The tracheostomy site was clean and dry. Suction equipment was present. The resident ' s respirations were even and unlabored.

On 9/13/22 at 10:00 am an interview was conducted with Nurse #2. Nurse #2 stated Resident #46 was known to ambulate with room air and the tracheostomy site can get dry. Nurse

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#2 stated she was not aware the oxygen concentrator was set to 5 liters and was unsure of the liter flow order. Nurse #2 stated she had not observed the oxygen liter flow this morning and would adjust the flow.

C. On 9/13/22 at 3:55 pm an observation was done of Nurse #3 providing tracheal suction for Resident #46 with the Director of Nursing (DON). Nurse #3 put on sterile gloves and asked the resident to remove the cap to her inner cannula. The resident was not able to remove the cap and Nurse #3 removed the cap. The nurse used her sterile gloves to touch items on the bedside table. The nurse used the same gloves to touch the suction catheter. Nurse #3 suctioned the resident and passed the catheter approximately 2 to 3 inches with a catheter sterile fluid flush 4 times and obtained thick white secretions. Suctioning did not cause cough. Audible rhonchi were heard, and the resident coughed after the procedure. The resident nodded yes that she felt better. The resident appeared to tolerate the procedure without breathing harder or distress. There was no oxygen saturation check and/or respiratory assessment of the resident. After the procedure an interview was conducted with Nurse #2. Nurse #2 stated she was not aware she did not follow a sterile procedure by keeping her sterile glove sterile to handle the suction catheter.

2. Resident #505 was admitted to the facility on 5/31/22 with the diagnoses of acute on chronic diastolic heart failure and chronic obstructive pulmonary disease.

Resident #505 ' s Minimum Data Set dated 6/5/22 documented the resident ' s cognition was intact.

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Resident #505 had a physician order dated 5/31/22 for 4 liters of oxygen by nasal cannula continuously.

A. Resident #505 ' s nurses' note dated 7/5/22 at 5:45 am documented the resident was noted to have oxygen saturation of 50% while on continuous positive airway pressure (CPAP). The resident was immediately placed on oxygen by nasal cannula at 8 liters to bring up his oxygen saturation while Emergency Medical Services (EMS) were dispatched and in route. The resident ' s oxygen saturation rose to 84% with no improvement. The note was written by Nurse #7.

Resident #505 was not available for interview. The resident expired at the hospital months later.

On 9/15/22 at 10:20 am an interview was conducted with Nurse #7. Nurse #7 stated she was assigned to Resident #505 night shift on 7/4/22 (morning of 7/5/22). The resident complained he had been short of breath during the night, but his oxygen saturation was within normal limits during the night. The resident was placed on his CPAP to sleep. "I cannot remember if the CPAP had an order to attach oxygen or if I attached oxygen." She stated another nurse informed her the resident was found in his room very short of breath. "The resident was in distress but able to talk. I called for Emergency Medical Services and the resident was sent to the hospital." Nurse #7 stated "the resident remained short of breath with oxygen by nasal cannula."

Resident #505 ' s emergency department (ED) record dated 7/5/22 documented the resident informed the physician that he ran out of oxygen

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while in his room for about 45 minutes. The resident called for staff, but they did not respond. The resident was dependent on continuous oxygen. The resident was provided oxygen by a non-rebreather mask and recovered quickly and was weaned to nasal cannula. The resident returned to the facility the same day.

B. A review of Resident #505 ' s facility record revealed he was sent to a cardiology appointment on 7/11/22.
A review of Resident #505 ' s cardiology office record dated 7/11/22 documented the resident arrived from the facility without oxygen in his tank and was in respiratory distress with an oxygen saturation of 80%. The resident was provided oxygen by nasal cannula and recovered.

On 9/12/22 at 12:15 pm an interview was conducted with the nurse at Resident #505 ' s cardiology physician office. She stated the resident was brought from the facility to the office for an appointment on 7/11/22. The oxygen tank that came from the facility was empty. The resident was in respiratory distress, cyanotic, and agitated. His oxygen level was 80%. She stated the resident reported this was not the first time he was without oxygen. The resident was provided 4 liters of oxygen by nasal cannula and recovered within 20 minutes. The resident cannot be without oxygen, he was dependent.

On 9/15/22 at 10:40 am an interview was conducted with the Transportation Coordinator. The coordinator stated she remembered Resident #505 and that the van driver who was responsible to take the resident to his appointment left without an oxygen tank. A tank was sent to the cardiology office for the resident

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to return.

On 9/16/22 at 2:40 pm an interview was conducted with the Interim Administrator and Corporate Nurse Consultant. The Interim Administrator stated she was not aware that Resident #505, oxygen dependent, was sent to an outside cardiology appointment without oxygen on one occasion and that the resident had respiratory distress.

The Administrator was notified of immediate jeopardy on 9/16/22.

The facility provided a credible allegation of immediate jeopardy removal.

Credible Allegation of Compliance

F695
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to provide ordered respiratory care that met the need for Resident #46 to maintain a clear airway from tracheal secretions which resulted in hypoxia and multiple trips to the emergency department to clear her airway.

Per interview with resident, center staff did not respond to resident #505 ' s call for help early morning 7/5/22 due to shortness of breath for a reported 45 minutes which resulted in hypoxia of 50% oxygen level. Resident stated he was not receiving oxygen; it had run out. Emergency medical services were required, and a non-rebreather oxygen mask (high level oxygen flow) was needed. For same resident, on 7/11/22

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the facility did not provide a full oxygen tank for Resident #505 ' s cardiology appointment. When the resident arrived at the office, he was in respiratory distress and the oxygen tank was found to be empty. Upon notification to the center, the center took a replacement oxygen tank to the MD office.

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

Resident #46 was assessed by the Director of Nursing (DON) on 9/15/22 and was noted as stable with trach care and suctioning. New orders were implemented between 9/13- 9/14/22 to include suctioning every four hours, and trach care every 12 hours and as needed. The DON verified the new orders were being implemented on the specific frequency, the new orders were validated to be present on the TAR for the ordered frequency, and the DON verified the respiratory equipment was functioning as intended. The care plan was updated on 9/16/22 to include every aspect of trach care, suctioning, and respiratory assessment.

A contracted Respiratory Therapist evaluated resident #46 on 9/16/22 and orders were updated as needed, to include suctioning documentation related to amount, consistency, color and odor, and documented through/in the supplemental documentation attached to the treatment administration record. No current patients are receiving trach care at the center.

In the event there is a concern during ordered trach care, the staff member cannot effectively

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suction a resident ' s trach care, and/or the trach tube become dislodged, the physician will be notified for follow-up, and this will be documented in the medical record for shift reporting, and for nursing administration during the 24-hour review. In the event of an trach tube becoming dislodged, nurse will use the beside ambu bag and/or replacement trach located at beside to aide in respirations.

Resident # 505 discharged on 7/26/22. Currently, there are five residents that are on either bipap or cpap therapies. Additionally, 26 patients are on oxygen therapy. Personalized care plans for residents with bipap, cpap and oxygen therapies were developed for all residents with oxygen to include every aspect such as supplemental oxygen, transportation with oxygen, application of oxygen to a CPAP/BiPAP. There were no new orders or recommendations by the Registered Respiratory Therapist, Respiratory Care Practitioner. (RTT, RCP)

Current nursing leadership to include DON, Assistant Director of Nursing (ADON) Staff Development Coordinator (SDC) and all nurse leadership received education on 9/16/22 by the center respiratory therapist regarding trach care to include: tracheostomy care, frequency of suctioning, respiratory assessment and documentation of such care, to include return demonstration, as well as caring for patients with cpaps, bipaps, and oxygen while in center and preparing for external appointments.

In turn, nurse leadership (DON, ADON SDC) provided full time, part time, as needed, and contracted nursing staff (agency) the same education with return demonstration on 9/16/22.

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Any staff assigned to a trach patient or patient with oxygen therapies will receive this education prior to the beginning of their shift, if not available on 9/16/22. This training will be added to the orientation program.

The individual responsible for this education is a registered respiratory therapist (RTT), respiratory care practitioner (RCP). As a contracted RTT RCP, she will be here weekly to monitor the trach patient, with monthly visits to review CPAP/BIPAP patients. She will also be available as needed to address any issues related to other respiratory care needs.

Alleged date of IJ removal is 9/17/22.

Person responsible for implementation is the administrator

The credible allegation was validated on 9/19/22.

On 9/19/22 at 12:00 pm an observation was done of the DON providing staff education and nursing staff provided return demonstration for tracheostomy care and tracheostomy suctioning. Both facility staff were able to correctly verbalize checking the order and the required respiratory assessment, when to contact the physician, and documentation. The staff also demonstrated where the oxygen tanks were stored, how to determine when they were empty, and check list that would be used for oxygen tank usage. Resident #46 had been emergently sent to the hospital on 9/18/22. The resident was taken to the operating room for airway management and placement of the tracheostomy tube.

On 9/19/22 at 12:25 pm an interview was

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F 695	Continued From page 48 conducted with the facility contracted RT (contract began on 9/16/22, first visit). The RT stated she provided staff education to nursing leadership and others on Friday 9/16/22 and evaluated the resident's humidification and tubing. The RT stated she would be responsible for the respiratory equipment, ongoing education, and evaluation of any residents with a tracheostomy for admission. The RT stated she would return today (9/19/22) and weekly for 4 weeks. The RT would be available for education and resident assessment. On 9/19/22 the current tracheostomy suctioning every 4 hours, 2 liters of oxygen by tracheostomy, tracheostomy care every 12 hours, including the inner cannula, and suction the tracheostomy as needed orders for Resident #46 were in her medication administration record. Immediate jeopardy was removed on 9/17/22 when the credible allegation was accepted.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		11/2/22

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F 725	Continued From page 49 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff, resident, and family the facility failed to provide sufficient nursing staff to meet the needs of the residents. The facility failed to provide activities of daily living for dependent residents who need help. This affected (Resident #75) and (Resident #355) 2 of 15 residents reviewed for staffing. Cross referring: Findings included: This tag is cross referenced to: 1.F 677: Based on observation, record review and interviews with resident and staff, the facility failed to provide incontinence care (Resident#75) and failed to provide personal hygiene and grooming (Resident #355) for 2 of 15 dependent residents reviewed for activities of daily living (ADL) care.	F 725	F725 1. Resident #75 is now receiving incontinence care as needed. Resident # 355 is now having her hair washed and brushed regularly. 2. Current Residents in the center who are dependent for ADL have the potential to be affected. 3. Current clinical staff will be educated by the DON/designee on Activities of Daily Living for dependent residents, including timely incontinence care and grooming and hygiene including brushing and combing hair to prevent tangles and washing hair on shower days Any nursing assistant who is not educated will not be allowed to work until education received. The Administrator, Director of Nursing and Director of Operations reviewed the facilities current recruitment plan for clinical staff to determine if additional	

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F 725	Continued From page 50 During an interview with Nursing Assistant (NA) #21 during the tour on 09/15/22 at 4:45am, NA #21 indicated they had been working in the facility for 3 plus years and indicated because the state had been in the facility all week, there was plenty of staff scheduled. NA #21 indicated that on a normal night we have up to 20 plus residents and it was hard to meet the needs of the residents. Staff indicated that some of the residents were wet and soaked by the time they get to them. Staff also indicated that the facility allow agencies staff to come in and the staff have no knowledge of what the residents need are or how to provide care for them. During an interview with a family member (FM) on 09/14/22 at 3:30pm, they had concerns about Resident #28 ' s care and indicated the facility had a staff shortage and at times Resident #28 had to wait for 45 minutes to over a hours before staff provided care and treatment. FM indicated that she understood Resident #28 ' s condition and now has hospice in place involved but the facility needed more staff. An interview was conducted with the Resident Council President on 09/15/22 at 2:00 pm and it was indicated the facility had been short of staff for months, he indicated that Residents complained to him about the waiting time for care and treatment from staff. He indicated many residents complained about being in bed during the late second shift and on third shift. On 9/16/22 at 5:10 pm an interview was conducted with the Administrator. She stated she only had been at the facility since August 1, 2022. The administrator indicated that her expectation was for staff to meet the needs of the residents in	F 725	resources are needed to ensure adequate staffing in the center. Any new nursing assistant will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process 4. DON or designee will audit 25 residents weekly for 2 months and then at least 25 residents monthly for 4 months to ensure compliance. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting for further resolution if needed. Date of completion: 11/2/2022	

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F 725	Continued From page 51 the facility. The administrator also indicated staffing was challenging and the facility had a lot of agency staff.	F 725		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		11/2/22

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F 726	Continued From page 52	F 726		

by:
Based on observations, record review and interviews of staff, contracted Respiratory Therapist, and Medical Director, the facility failed to train nursing staff and verify competency to provide for and to meet the respiratory care needs for 1 of 1 resident reviewed for tracheostomy care. Resident #46 required 5 trips to the Emergency Department (ED) over a two and a half week period of time to clear her airway and treat hypoxia as a result of staff not maintaining a clear airway from tracheal secretions.

Immediate jeopardy began on 8/26/22 when the failure to train and verify competence of nursing staff resulted in the necessary tracheostomy care not being provided and Resident #46 had to be sent to the ED for tracheal tube obstruction, large amounts of secretions, and loss of her tracheostomy tube. Immediate jeopardy was removed on 9/17/22 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of an "E" which is no actual harm with potential for more than minimal harm that is not immediate jeopardy to complete staff education and ensure monitoring systems put in place are effective.

Findings included:

Resident #46 was admitted to the facility on 7/12/22 with the diagnosis of acute respiratory failure. The admission history indicated the resident was admitted for tracheostomy tube management.

Resident #46's admission Minimum Data Set

F726 Nursing Competency

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident #46 was assessed by the Director of Nursing on 9/15/22 and noted stable respiratory status. New orders were implemented between 9/13- 9/14/22 to include suctioning every four hours, and tracheostomy care every 12 hours and as needed. On 9/15/22, The Director of Nursing verified the new orders were being implemented as ordered, the new orders were validated to be present on the Treatment Administration Record for the ordered frequency, and the Director of Nursing also verified the respiratory equipment was functioning correctly. The MDS Nurse updated Resident #46□s care plan on 9/16/22 to include the following aspects of tracheostomy care: securing trach ties, assessment and monitoring, oxygen settings, suctioning as ordered, and trach care.

A respiratory therapist evaluated resident #46 on 9/16/22 and orders were updated to include suctioning documentation related to amount, consistency, color and odor, and documented through/in the supplemental documentation attached to the treatment administration record

- 2 Address how the facility will identify

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F 726	Continued From page 53 (MDS) dated 7/18/22 documented the resident had an intact cognition and no refusal of care. Treatments included tracheostomy care and suctioning. Resident #46's physician orders dated 7/12/22 included, in part: - Tracheostomy care every shift and as needed. Clean or change the inner cannula as applicable. Specify inner cannula size 6. - Suction excess secretions as needed On 9/13/22 at 3:15 pm an interview was conducted with the Medical Director (MD). The MD clarified his order for tracheostomy care each shift meant every twelve hours (nursing had 12 hours shifts) and included suctioning the resident at least once a shift, but this was not how the order was written on 7/12/22. On 9/13/22 at 3:15 pm an interview was conducted with Unit Supervisor #1. She stated she was not aware the physician expected nursing staff to suction Resident #46 each shift with the tracheostomy care. She stated she was aware there was an order for tracheostomy suctioning as needed. She stated that nursing staff were responsible for all respiratory care including the equipment, there was no Respiratory Therapist. a. On 8/26/22, a nurse's note was documented by Nurse #6. Resident #46 had a change of condition due to an obstructed tracheostomy tube. The resident's oxygen level was 95% out of 100%, pulse was 80, and respirations were 19. The Nurse Practitioner (NP) was called and gave orders to send the resident to the ED.	F 726	other residents having the potential to be affected by the same deficient practice; The Director of Nursing reviewed a list of residents currently residing in the facility and found there were no other residents with a tracheostomy that would require tracheostomy care. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Facility contracted with respiratory therapist on 9/16/2022. Current nursing leadership to include Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) received education with return demonstration on 9/16/22 by the center respiratory therapist regarding tracheostomy care to include: tracheostomy care, frequency of suctioning and reassessment of resident□s oxygen status and need for re-suctioning, respiratory assessment, and documentation of such care. In turn, nurse leadership (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator) provided full time, part time, as needed, and contracted nursing staff (agency) the same education with return demonstration on 9/16/22. Any staff assigned to a tracheostomy patient or patient with oxygen therapies will receive this	

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F 726	Continued From page 54 The Emergency Department (ED) record dated 8/26/22 documented Resident #46 was seen for tracheal tube obstruction. The facility informed the ED that they were unable to suction the resident. No inner cannula was in place from the facility, and one was placed in the ED. The Respiratory Therapist (RT) was unable to pass a suction catheter because of secretions and mucous accumulation and hardening causing a partial obstruction. The ear nose and throat (ENT) physician changed the tracheostomy tube. The resident was observed for two- and one-half hours and returned to the facility. On 9/14/22 at 11:40 an interview was conducted with Nurse #6. She stated, "I was assigned to Resident #46 on 8/26/22. I was not able to pass the suction catheter and suction the resident." She said she typically suctioned when she completed tracheostomy care. Nurse #6 stated she did not listen to the resident's lungs. She reported that she participated in a tracheostomy in-service when Resident #46 was first admitted. Nurse #6 stated this was her first tracheostomy care resident. b. On 8/30/22 a nurse's note was documented and indicated Resident #46 coughed, and her tracheostomy tube came out (it was not noted if the inner cannula was in place). All efforts to replace the tracheostomy by staff were not successful. Emergency Medical Services (EMS) were contacted, and the resident was taken to the emergency room. The ED note dated 8/30/22 documented Resident #46 was seen and diagnosed with tracheostomy	F 726	education prior to the beginning of their shift, if not available on 9/16/22. On 9/26/22, The Administrator, Director of Nursing, and Regional Director of Clinical Services conducted an in-depth analysis of the mechanisms, policies , training of nursing staff relative to Respiratory Care and determined the following would continue to be implemented: Education and training on Respiratory Care which includes: Tracheostomy care, Tracheostomy suctioning, respiratory assessment and documentation of such care, and caring to residents with CPAP, BIPAP, and Oxygen while in the facility and preparing for external appointments. In the event there is a concern during ordered tracheostomy care such as the staff member cannot effectively suction the tracheostomy and/or the tracheal tube becomes dislodged, the physician and/or Non Physician Practitioner will be notified for further follow up. This notification and any new instructions/orders will be documented in the resident□s medical record. This education will continue to be provided to all newly hired staff during Facility Orientation as well as annual clinical competencies. The facility will continue to require any Staffing Agency used provide validation that Respiratory Care Training has been validated on all their licensed nurses prior to them working at the facility. The Director of Nursing and/or designee will be responsible for validating staff are	

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F 726	Continued From page 55 tube change and aspiration pneumonia of the left lung. The resident required suctioning by the RT and the cough improved. Antibiotics were ordered. The resident was suctioned, tracheostomy tube was changed, and she returned to the facility. The resident maintained her oxygen level with use of oxygen while in the ED. On 9/16/22 at 12:30 pm an interview was conducted with the facility contracted Respiratory Therapist (RT) hired on 9/16/22. She stated that nursing should not replace a tracheostomy tube because they were not trained to properly perform this. She stated that EMS should be called. She stated that the resident should be suctioned as needed to clear the rhonchi and cough. Cough can contribute to loss of the tracheostomy tube. She stated repeated loss of a tracheostomy tube was not usual. c. The ED note dated 9/4/22 documented Resident #46 was seen for dried secretions and tracheostomy change due to secretion accumulation. The inner cannula was not present when the resident arrived at the ED and the Ear Nose and Throat (ENT) Physician recommended the resident have a disposable inner cannula in place at all times to prevent crust and secretion accumulation. The resident was suctioned of a large amount of secretions. The resident reported to the ED Staff the tracheostomy was dislodged due to coughing secretions and she was feeling short of breath. The resident had increased work of breathing and oxygen was provided at the ED until the tube was changed. There was no corresponding nurse's note for the	F 726	competent in Respiratory Care. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing, Assistant Director of Nursing, and/or Nurse Consultants will review the orientation material for all newly hired licensed nurses to assure Respiratory Care Training with return demonstration was provided and clinical competency met. This will be accomplished for any contracted agency nurses by reviewing their competency validation list completed by the staffing agency when hired. This monitoring will be completed weekly for four weeks and then monthly for 5 months. The Director of Nursing, Assistant Director of Nursing, Nurse Consultants and/or Respiratory Therapist will monitor tracheostomy care (as long as there are residents with tracheostomy care in the facility) through direct observation, nursing documentation and nursing interviews at least 2 times each week for one month, then weekly for one month. Thereafter the monitoring will be completed monthly for at least 4 months. Results will be recorded on an audit tool titled Respiratory Care. Results will be	

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F 726	Continued From page 56 9/4/22 ED evaluation. d. On 9/9/22 Nurse #1 documented a nurse's note. Resident #46 came out into the hall with her tracheostomy in her hand. She had coughed the tracheostomy out and staff was unable to replace. The resident was sent to the ED. No oxygen level was documented in this nurse's note. Resident #46's ED documentation dated 9/9/22 indicated ENT had inserted a size 4 (smaller) tracheostomy cannula in place of the size 6 tracheostomy cannula that was dislodged due to coughing and lodged secretions. The resident received oxygen to increase her oxygen level from 90% to 98%. The ED physician was unable to place a size 6. The facility reported to ED staff they were unable to suction the resident at the facility due to thick, dry secretions. The hospital documented discharge instructions to change the inner cannula every 12 hours and to suction the tracheostomy every 4 hours to prevent clogging. An order was provided to follow up with ENT to be evaluated to have a surgical procedure to enlarge the tracheostomy again. Nurse #1 was not available for interview. e. Resident #46's nurse's note dated 9/12/22 documented that the resident complained about not being able to breathe. The resident was suctioned a few times. Oxygen reading was 88% out of 100% and heart rate was 133. The Nurse Practitioner was called and provided an order to send the resident out to the ED.	F 726	reported to the Quality Assurance Performance Committee by the Director of Nursing monthly and results reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Date of completion: 11/2/2022	

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Resident #46's ED note dated 9/12/22 documented the resident was unable to breathe due to secretions. The resident had secretions that the facility, reportedly, was not able to suction and clear without significant relief. EMS documented resident was hypoxic (low in oxygen) in the high 80s oxygen reading (out of 100). The resident had increased work of breathing. with oxygen saturation of 90% on room air. The diagnosis was clogged tracheostomy tube with thick clear secretions that the hospital RT had to clear. Coarse rhonchi were cleared after suctioning. The oxygen saturation was 96% on room air after suctioning. The chest x-ray had no acute findings. The resident was stable for discharge back to the facility.

On 9/14/22 at 5:50 am an observation was done of Resident #46. She was sleeping in her bed with the head of the bed elevated approximately 30 degrees. The resident's tracheostomy dressing was clean and dry. Her mist collar (provides humidification to the tracheostomy) was in place but was dry and not misting.

On 9/14/22 at 5:40 am an interview with Nurse #3. She stated she worked here 2 months and was agency staff. She indicated she had worked with Resident #46 and provided tracheostomy care that included suctioning but had not been provided education for tracheostomy care and/or suctioning by the facility. She stated she had a concern that the mist collar was not moist this shift, it appeared dry. There was no mist observed.

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On 9/14/22 at 8:10 am an observation was conducted of Resident #46 with assigned Nurse #4. The resident was ambulating in her room and not wearing the mist collar. The collar was sitting on the humidification device, and it was not misting. The resident coughed and rhonchi were audible, and she was holding her tracheostomy in place. Interview with Resident #4, she stated the mist collar was "dry." Nurse #4 was concurrently interviewed and stated she was not aware the mist collar was not working. Nurse #4 stated she did not know how to correct the mist/humidification device.

On 9/16/22 at 12:30 pm an interview was conducted with the facility contracted Respiratory Therapist hired on 9/16/22. She stated that the tracheostomy collar mist device was not properly set up and was not misting as intended for an unknown period. Secretions can become dry and occlude when humidification was not provided. Occlusion can cause hypoxia and an inability to pass the suction catheter.

On 9/13/22 at 10:00 am an interview was conducted with Nurse #2. Nurse #2 stated she had not received in-service for tracheostomy care and was assigned to a resident with a tracheostomy.

On 9/13/22 at 3:30 pm an interview was conducted with the Medical Director (MD). The MD stated that he was not aware Resident #46 was seen in the Emergency Department (ED) 5 times in the last 3 weeks due to a mucous-plugged or loss of her tracheostomy tube. The staff had called the Nurse Practitioner and she had addressed the concerns by sending the resident to the ED. A stable tracheostomy

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would not need to be sent to the ED for this frequency. The MD stated Resident #46's tracheostomy was no longer stable. The Medical Director revealed when Resident #46 was admitted to the facility with a tracheostomy he had concerns that nursing would not be capable to manage the resident's tracheostomy. There was currently 70% agency nursing staff that he was not sure could manage or was trained in tracheostomy care. The Medical Director stated he informed the facility they could not take another tracheostomy resident. The Medical Director stated he had a discussion with corporate staff and administration that there were concerns with nurse staffing and care provided.

The Administrator was notified of immediate jeopardy on 9/16/22.

The facility provided a credible allegation of immediate jeopardy removal.

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

The facility failed to document the resident's tracheal suctioning frequency, how the resident tolerated suctioning, and what was retrieved. The facility failed to provide adequate training to staff, including agency staff and hires including: tracheostomy care, including suctioning, respiratory assessment, and steps to take when a resident requires additional suctioning or is hypoxic.

Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete;

Resident #46 was assessed by the Director of Nursing (DON) on 9/15/22 and was noted as stable with trach care and suctioning. New orders were implemented between 9/13- 9/14/22 to include suctioning every four hours, and trach care every 12 hours and as needed. The DON verified the new orders were being implemented on the specific frequency, the new orders were validated to be present on the TAR for the ordered frequency, and the DON verified the respiratory equipment was functioning as intended. The care plan was updated on 9/16/22 to include every aspect of trach care, suctioning, and respiratory assessment.

A contracted respiratory therapist evaluated resident #46 on 9/16/22 and orders were updated as needed, to include suctioning documentation related to amount, consistency, color and odor. No other current patients are receiving trach care at the center.

In the event there is a concern during ordered trach care, the staff member cannot effectively suction a resident's trach care, and/or the trach tube become dislodged, the physician will be notified for follow-up, and this will be documented in the medical record for shift reporting, and for nursing administration during the 24-hour review.

Current nursing leadership to include DON, Assistant Director of Nursing (ADON) Staff Development Coordinator (SDC) and all nurse leadership received education on 9/16/22 by a contracted registered respiratory therapist (RTT), respiratory care practitioner (RCP), contracted on

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9/16/22, according to professional standards of tracheostomy care. Training with return demonstration included: tracheostomy care, tracheal suctioning, how to manage a dislodged tracheal tube, and documentation of care provided.

In turn, nurse leadership (DON, ADON SDC) provided full time, part time, as needed, and contracted nursing staff (agency) the same education with return demonstration on 9/16/22. Any staff assigned to a trach patient will receive this education prior to the beginning of their shift, if not available on 9/16/22. This education with return demonstration will be added to all future orientations and as needed when tracheostomy patients are admitted.

The individual responsible for this education is a registered respiratory therapist (RTT), respiratory care practitioner (RCP). The contracted RTT, RCP will be here weekly to monitor the trach patient, with monthly visits to review CPAP/BIPAP patients. She will also be available as needed to address any issues related to respiratory care needs.

Alleged date of immediate jeopardy removal is 9/17/22.

Person responsible for implementation is the Administrator.

The credible allegation of immediate jeopardy removal was verified on 9/19/22 by onsite validation. On 9/19/22 at 1:15 pm an observation was done of nursing education and return demonstration for respiratory care/tracheostomy

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F 726	Continued From page 62 suctioning of Nurse #14 and Unit Supervisor #1 according to the credible allegation requirements. The nursing in-service signed roster was reviewed. The skills check list had all required components for tracheostomy care and suctioning. The list was reviewed by the contracted Respiratory Therapist. A Respiratory Therapist (RT) was contracted on 9/16/22 to oversee all respiratory care, education, and equipment. The RT completed education and return demonstration of all nursing management on 9/16/22. The facility's immediate jeopardy removal date was determined to be 9/17/21 based on the validation.	F 726		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a registered nurse (RN) for at least 8 consecutive hours (hrs.) a day for 20 of 62 days reviewed (7/28/22, 7/31/22, 8/2/22, 8/5/22, 8/7/22, 8/8/22, 8/9/22, 8/11/22, 8/12/22,	F 727	F727 1. On 9/16/22 the Administrator educated the Nursing Scheduler on the need to ensure a Registered Nurse is	11/2/22

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F 727	Continued From page 63 8/14/22, 8/16/22, 8/18/22, 8/22/22, 8/23/22, 8/24/22, 8/25/22, 8/26/22, 8/27/22, 8/28/22, and 8/30/22). Findings included: A review of the facility ' s timecard period summary report from 7/1/22 through 8/31/22 revealed on 7/28/22, 7/31/22, 8/2/22, 8/5/22, 8/7/22, 8/8/22, 8/9/22, 8/11/22, 8/12/22, 8/14/22, 8/16/22, 8/18/22, 8/22/22, 8/23/22, 8/24/22, 8/25/22, 8/26/22, 8/27/22, 8/28/22, and 8/30/22) the facility did not have 8 consecutive hours of RN coverage. During an interview with the Scheduler on 9/16/22 at 9:46 AM, she indicated she had been in the position since Thursday September 8, 2022. She indicated she schedules at least 1 RN every day of the week for at least 8 hrs. The scheduler also indicated Monday through Friday she can use the Minimum Data Set (MDS) Nurse as the RN coverage and on the weekends was when she had to ensure there was an RN on duty for 8 hrs. During an interview on 9/16/22 at 11:22 AM, the Director of Nursing it was indicated she had just started at the facility, however it was her expectation for the facility to have 8 hours (hrs.) of RN coverage in a 24-hr. period. During an interview that was conducted on 9/16/22 at 11:31 AM, the regional director of clinical services #1 indicated they had always included the MDS Nurse in RN coverage. During an interview on 9/16/22 at 11:33 AM, the Administrator indicated it was her expectation the facility had 8 hrs. of consecutive RN coverage	F 727	scheduled at least 8 hours per day/7 days a week. 2. Center residents in the center have the potential to be affected. The Nursing Scheduler reviewed the schedule for the upcoming four (4) weeks to ensure a Registered Nurse was scheduled for each day. Compliance was noted. 3. The Director of Nursing will continue to review the monthly staffing schedule daily to ensure a Registered Nurse is scheduled for at least 8 hours a day. Any Registered Nurse who cannot work their assigned shift must call in directly to the Director of Nursing. The Administrator, Director of Nursing and Director of Operations reviewed the facilities current recruitment plan for Registered Nurses. 9/29/22. This includes the review of the current contracts the center has with staffing agencies to provide a variety of personnel on an as needed basis that includes Registered Nurses. The facility Management reviewed and approved the following incentives for staff recruitment and retention, specifically for RNs, to exceed industry standards and other health care providers, so to assure recruitment is competitive. A Retention bonus is offered for all current RN openings, payable in increments after hire. The Director of Nursing will prioritize RN applicants for interviews. 4. The DON/Administrator/designee will monitor the nursing schedule daily to ensure there is 8 hours of consecutive RN coverage for the center. 5. The results of recruitment of RN recruitment and the daily review of RN	

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F 727	Continued From page 64 every day.	F 727	coverage will be discussed at the monthly QAPI meeting. If compliance is not noted related to RN coverage, the center will continue to update/revise the recruitment plan and plan for RN coverage. Once the QAPI committee determines the problem no longer exits the audits will be completed on a random basis. Date of completion: 11/2/2022	
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].	F 741		11/2/22

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F 741	Continued From page 65 §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff received the required training for assisting residents with dementia for three (3) of six (6) staff records reviewed, Nurse #28; Nurse aide (NA) #11 and NA #12. The findings include: Review of the facility assessment updated in 1/2022 and reviewed by QAPI in April 2022 revealed the facility had dementia residents. a) During an interview with the Nurse #28 on 9/14/22 at 5:15 AM, she indicated she was agency staff and has been working for the facility for about 2 months. She indicated she did not receive any dementia training that was provided by the facility. Review of the Nurse #28 start date with the Human resource (HR) staff revealed, based on the time clock the staff started to work for the facility on 8/13/22. Inservice / education records dated 9/4/22 and 9/5/22 for "Agency nurse orientation" related to "providing high quality Dementia care an overview" were reviewed. The sign in sheet did not contain the nurse's name or signature. b) During an interview on 9/14/22 at 5:20 AM NA #11 indicated she was an agency staff and had been working for the facility for past 2 months. NA #11 stated she had not received	F 741	F741 1. Dementia education given to current staff including agency staff 2. Current residents in the center with a diagnosis of dementia have the potential to be affected. 3. Current staff including agency staff will be educated on Dementia training by Staff Development Nurse or designee Any staff member not receiving Dementia training will not be allowed to work until education received. Any new staff member will be educated by Staff Development Nurse of Director of Nursing or designee during orientation process 4. Director of Nursing /SDC or designee will audit at least 5 employees including agency dementia training signature sheet weekly x 4 weeks, then 3 employees x 8 weeks, then monthly x 2. Results of audits will be reviewed at Quarterly Quality Assurance Meeting x 2 for further resolution if needed. Date of completion : 11/2/2022	

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dementia training by the facility but knew how to take care of Dementia residents.

Review of the NA #11 start date with the HR revealed, based on the time clock the staff started to work for the facility on 3/3/22.

c) During an interview on 9/14/22 at 5:35 AM NA #12 stated she was an agency staff and had been working for the facility for past one week. She further stated she had not received dementia training by the facility.

Review of the NA #12 start date with the HR revealed, based on the time clock the staff started to work for the facility on 6/19/22.

During an interview with the Administrator and Regional Director of Clinical Services #1 on 9/14/22 at 2:00 PM, they indicated the former Director of Nursing (DON) had made a binder with all polices and training that included infection control and Dementia. All agency staff have to read/ review this information prior to be working on the floor. The Staff Development Coordinator (SDC) provided training and in-services to agency staff.

During an interview on 09/16/22 10:13 AM, previous DON #2 stated she working for the facility from June to August 2022 and was an interim DON. DON #2 indicated that SDC was responsible for orientation and training for all staff member (both agency and facility staff). DON #2 stated she had started doing in-services like abuse and other issues where both facility and agency staff were involved. She further stated all Dementia training for facility staff were completed on-line on "Relias" and was unsure if the agency

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F 741	Continued From page 67 staff had access to on-line training. She indicated staffing agency was responsible to ensure all agency staff received training and SDC had to check these training prior to the staff working on the floor. DON #2 indicated she was unsure if SDC had checked for these training. During a telephone interview with the SDC on 9/15/22 at 4:00 PM, she indicated she was the interim SDC and had started working in the facility for just a week. The SDC further stated she had not started any in-services or training to staff. The previous SDC was unable to be interviewed at the time of the survey. During an interview with the administrator on 9/15/22 at 1:45 PM, she indicated she was unable to find any training documentation for the requested staff members. The Administrator further indicated that all dementia training and infection control training was completed online " Relias" and the SDC was responsible to ensure that all staff members had completed these training. She added going forward the facility would be putting a plan to include agency nurse and nurse aides for dementia training.	F 741		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		11/2/22

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F 755	Continued From page 68 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, pharmacist interview, and Physician interview, the facility failed to provide access to over-the-counter pain patches (Salonpas pain relief patch) for a resident with joint pain (Resident #42) resulting in two missed doses of the pain medication. This occurred for 1 of 10 residents reviewed for pharmacy services. The findings included: Resident #42 was readmitted to the facility on 6/15/21. Diagnoses included arthropathy (disease	F 755	F755 1. Resident #42 missed Salonpas pain relief patch was reported to medical provider no new orders. 2. Current residents receiving the Salonpas patch for pain relief has the potential to be affected. 3. Current licensed nurses will be educated by SDC/DON or designee that medications are to be administered as ordered including any patches being used for pain control. If the medication is	

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F 755	Continued From page 69 of joints) and polyosteoarthritis (joint pain and swelling). Resident #42 was ordered Salonpas pain relief patch on 5/25/22. It was to be applied to the left shoulder daily. Resident #42's quarterly Minimum Data Set (MDS) dated 7/14/22 revealed the resident was cognitively intact. On 8/20/22, Nurse #12 indicated on the Medication Administration Record (MAR) she administered a Salonpas pain patch for Resident #42. A progress note dated 8/20/22, however, indicated the medication was not given, stating the resident's medication was unavailable. On 8/21/22, Nurse #12 indicated on the MAR the Salonpas pain patch was not administered for resident #42. A progress note dated 8/21/22 confirmed Nurse #12 did not administer the Salonpas patch as it was unavailable. The pain assessment was not completed on the MAR for dayshift on 8/20/22 and 8/21/22. The pain level was documented as "0" on the MAR for nightshift on 8/20/22 and 8/21/22. Attempts to interview Nurse #12 on 9/13/22 were unsuccessful. Observations of Resident #42 on 9/12/22 at 1:48 PM and 9/15/22 at 9:10 AM revealed she was wearing the Salonpas pain patch to her left shoulder. During an interview with Resident #42 on 9/12/22 at 1:48 PM, she stated the facility had run out of the pain patches in the past. She did not recall the dates when she was not	F 755	unable to be administered, the provider and pharmacy are notified for alternative treatment if possible. Any licensed nurse that has not received education will not be allowed to work until education received Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of administering pain patch medications 4. DON or designee will audit 10% of pain patch medications for weekly for 2 months and then at least 25 residents monthly for 4 months to ensure compliance. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting for further resolution if needed. Date of completion: 11/2/2022	

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administered the pain patch.

During an interview with Nurse #10 on 9/13/22 at 9:26 AM, she stated when Salonpas patches were unavailable, nurses would contact Central Supply for more patches. Observation of Nurse #10's medication cart during the interview revealed there were two boxes of Salonpas patches available.

An interview was conducted with Central Supply on 9/13/22 at 2:30 PM. She stated she ordered over-the-counter (OTC) medications for the facility. Central Supply revealed there was not a process for obtaining stocked OTC medications when they ran out over the weekend. During the week, nurses notified her when they needed Salonpas patches for the weekend. If the nurse doesn't ask for the patches, she would not know they needed it. During the weekend of 8/20/22 and 8/21/22, Salonpas patches were locked in her office desk and inaccessible to nurses. They were locked up so that no one would steal them. Currently, the patches were accessible in the medication supply room as well as a shelf in her office.

An interview was conducted with Pharmacist #1 on 9/14/22 at 9:30 AM. Pharmacist #1 stated Resident #42 had an active order for Salonpas patches. The pharmacy last dispensed the medication to the facility in May of 2022. On 6/1/22, the corporate office instructed the pharmacy to no longer dispense most OTC medications, including Salonpas pain patches. Since then, the facility's central supply staff provided the pain patch. If an OTC medication was unavailable, the facility could send a one-time authorization request to receive the

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F 755	Continued From page 71 medication from the pharmacy. During an interview with Nurse #6 on 9/14/22 at 10:35 AM, she stated she was aware the Salonpas patches were not administered to Resident #42 on 8/20/22 and 8/21/22. Nurse #6 asked Nurse #12 to get an order for an alternate medication. It was unknown if Nurse #12 called the physician. An interview was conducted with Administrator #1 on 9/14/22 at 1:00 PM. She stated she was unaware Resident #42 did not receive pain patches on 8/20/22 and 8/21/22. Administrator #1 stated she had not been asked to authorize a request for the Salonpas pain patches. An interview was conducted with Nurse Practitioner (NP) #2 on 9/14/22 at 2:16 PM. NP #2 stated she was not notified that Resident #42 did not receive her pain patches. She further explained not receiving the Salonpas pain patches would mean Resident #42's pain was uncontrolled. An interview was conducted with Physician #1 on 9/15/22 at 10:19 AM. He stated he was not aware Resident #42 did not receive Salonpas patches on 8/20/22 and 8/21/22. During an interview with the Assistant Director of Nursing (ADON) on 9/15/22 at 2:41 PM, she confirmed Nurse #12 documented the Salonpas patches were not given on 8/20/22 and 8/21/22. Progress notes indicated the patch was not available on those days.	F 755		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		11/2/22

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F 760	Continued From page 72 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, staff interviews, family interview, pharmacist interview, and physician interviews, the facility failed to provide prescribed antiseizure medication for 1 of 10 residents (Resident #140) reviewed for medication errors. Resident #140 did not receive prescribed Vimpat (antiseizure medication) from 6/26/22 - 7/10/22 and from 7/14/22 - 7/21/22. This resulted in the resident not receiving 45 doses of antiseizure medication. Immediate jeopardy began on 6/26/22 when the facility failed to obtain Resident #140's antiseizure medication. Immediate jeopardy was removed on 9/17/22 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put in place are effective. The findings included: Resident #140 was admitted to the facility on 10/12/20. Diagnoses included epilepsy (seizure disorder) and Wernicke's encephalopathy (degenerative brain disorder). Resident #140's care plan, created 11/3/21 and revised on 1/20/22, revealed a focus area for seizures. Interventions included provided	F 760	F760 Medication Error # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #140 - Nurse Practitioner #1 was made aware of the missed medication on 9/14/22 during survey. Nurse Practitioner #2 was made aware of the missed medication for Resident #140 on 9/16/22 during survey. Physician #1 was made aware of the missed medication on 9/15/22 during survey. Resident #140 received Vimpat as ordered on 7/21/22, once the medication was made available via generic medication order/insurance authorization. Consultant reviewed the medication administration record on 10/7/22 and Resident #140 has received the Vimpat since the date of allegation of compliance on 9/17/22 # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/15/22 The Assistant Director of Nursing (ADON) reviewed medication orders for all current residents receiving	

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F 760	Continued From page 73 medications as ordered. The annual minimum data set (MDS) dated 5/5/22 revealed Resident #140 was moderately cognitively impaired. Resident #140 had an order dated 5/25/22 to give Depakote (antiseizure medication) delayed release 500 milligrams (MG). He received two tablets by mouth every 12 hours for seizures. Resident #140 was initially ordered Vimpat on 10/12/20. The order dated 5/27/22 revealed Vimpat 200 MG give one tablet by mouth two times a day for seizures, controlled substance. A progress note by Nurse Practitioner (NP) #2 dated 6/7/22 indicated Resident #140 was seen for an assessment. It was noted Resident #140 had seizures and was managed on Vimpat and Depakote (antiseizure medications). No seizure activity was documented or reported by the resident. A nurse progress note written by Director of Nursing (DON) #2 dated 6/24/22 at 2:06 PM indicated there was a follow up with the neurologist's office for a replacement medication for Vimpat. The neurologist office sent a new prescription on 6/24 after speaking with the facility nurse. The pharmacy received the prescription (unreadable) on 6/25/22. Review of controlled substance records revealed nurses administered Vimpat to Resident #140 until 6/26/22 when the medication became unavailable. The resident did not receive	F 760	seizure medications to assure that medications were available. Compliance was noted (all residents had the prescribed amount of medication). On 10/10/22 the Director of Nursing, Assistant Administrator, Assistant Director of Nursing began reviewing all current resident□s medication administration record and treatment administration record to ensure all medications and treatments were administered as ordered. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 9/16/22 The Regional Director of Clinical Services and Vice President of Operations developed an internal facility protocol to reconcile medication orders with the pharmacy and to ensure residents received medications as ordered. The internal facility protocol includes: 1. receive clarification for a medication hold order, and/or 2. request alternative orders while original order is being processed or provided by pharmacy or while insurance authorization is being obtained. 3. Follow-up with the pharmacy to understand the cause of medication unavailability with immediate resolution. 4. Follow-up to internal provider (Physician and or Non-Physician Practitioner) if specialist office is not available immediately for follow-up orders.	

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F 760	Continued From page 74 prescribed Vimpat from 6/26/22 - 7/9/22 or from 7/14/22 - 7/21/22. Resident #140 received Vimpat from 7/10/22 - 7/13/22 when a 3-day emergency supply had been authorized and dispensed to the facility by the pharmacy. An interview was conducted with Resident #140's family member on 9/12/22 at 11:40 AM. The family member stated they received a notification from the pharmacy stating Vimpat would no longer be on the formulary (a formulary was a list of medications that were available and provided by the pharmacy). The family member gave the information to Nurse #6 and did not hear back from the facility. At some point, the Neurologist faxed over a generic prescription to the facility, but the family member learned it was not covered by insurance either. The family member completed paperwork and was told Resident #140 did not qualify for the medication assistance program. The family member did not know how long the resident was without Vimpat but had documentation that showed the Vimpat was filled for a 3-day supply in July and again on 7/22/22. An interview was conducted with Nurse #10 on 9/13/22 at 10:52 AM. She stated resident #140 went without his Vimpat for "awhile." Nurse #10 did not know exactly how long the resident was without the medication. She indicated, in June 2022, Nurse #6 informed her there was a pharmacy and insurance issue with Resident #140's Vimpat. During an interview with Nurse #6 on 9/14/22 at 10:35 AM, she stated Resident #140 did not receive his Vimpat in June 2022 after the pharmacy could not refill it due to issues with insurance coverage. The NP was notified by	F 760	5. Medication Aides will notify a Licensed Nurse if medications are not available, if alternative orders are needed, or clarification orders are needed for a medication hold order. On 9/16/22, Education was provided on the protocol for notifying the Physician and/or Non-Physician Practitioner when medications are not available by the Director of Nursing, or Staff Development Coordinator to all full time, part time, as needed, and contracted nursing staff (if applicable) on proper notification to providers, including Physician and NP, when a medication is unavailable. Staff not working on 9/16/22 will receive education prior to the start of their shift after 9/16/22. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing, Assistant Director of Nursing, Nursing Supervisors, and/or Nurse Consultants will review the Medication Administration Records against the medication supplies for 25 residents weekly for 2 months and then at least 25 residents monthly for 4 months to ensure that medications are available and administered as ordered. When medications were not administered as	

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F 760	Continued From page 75 Nurse #6 and requested staff contact the neurologist. Nurse #6 indicated she did not contact the neurologist and an unknown nurse had called the neurology office. Nurse #6 explained Resident #140 did not receive Vimpat during June 2022 and July 2022. No medications were prescribed in the place of Vimpat. Resident #140 had received Depakote since 10/2020. An interview was conducted with NP #1 on 9/14/22 at 10:45 AM. NP #1 stated she was notified in June 2022 that Resident #140's Vimpat was not available. NP #1 discussed the issue in a meeting with Administrator #2, the DON at the time, and the unit managers. NP #1 informed the staff Resident #140 could not go without Vimpat and could end up in the hospital. Administrator #2 assured NP #1 the medication would be obtained, and the facility could cover the cost if needed. NP #1 understood the medication would be provided and was unaware the Vimpat continued to not be administered. During an interview with Pharmacist #1 on 9/14/22 at 11:03 AM, she stated there were no insurance coverage issues or prior authorization requests for Resident #140's Vimpat. The dispensing history was as follows: On 6/25/22, the pharmacy received a fax from the facility that was unreadable. The pharmacist at the time spoke with a nurse aide (name unknown) at the facility. The nurse aide told the pharmacist they would have the nurse fax over the prescription. No refax was obtained. On 7/9/22 a verbal authorization was received for an emergency 3-day supply of Vimpat for Resident #140, and it was dispensed. On 7/22/22, a new prescription was received for Vimpat, and it was dispensed.	F 760	ordered the chart will then be reviewed to determine if the Physician or Non Physician Practitioner was notified. The results of the audit will be documented on an audit tool entitled Medication Match-back Audit . Results will be reviewed and discussed in the Quality Assurance Performance improvement Committee meetings monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Date of completion: 11/2/2022	

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An interview was conducted with former Administrator #2 on 9/14/22 at 11:17 AM. She did not recall Resident #140, the medication, or being notified the resident's Vimpat was not available.

During an interview with the Regional Director of Clinical Services #1 on 9/14/22 at 1:00 PM, she stated nurses should call the physician for further orders when a medication was not available in the medication backup system.

An interview was conducted with Physician #1 on 9/15/22 at 10:19 AM. Physician #1 stated he was not aware Resident #140 did not receive Vimpat. He indicated not receiving a medication such as Vimpat was a very serious problem, and the resident could have had seizures that he wouldn't have otherwise. Resident #140 was on Depakote and Vimpat was ordered to stop recurrent seizures that were not maintained on Depakote alone. Physician #1 stated residents should receive medications as ordered and without delay. He considered missing Vimpat a significant medication error and indicated abruptly stopping the medication could result in withdrawals.

During an interview with NP #2 on 9/16/22 at 9:41 AM, she stated in June 2022 Nurse #6 informed her Resident #140's Vimpat was not available. NP #2 explained she was told there was an issue with insurance and the medication would not be covered. The NP further indicated Resident #140 needed the Vimpat but was on Depakote while the Vimpat was not available. NP #2 believed Nurse #6 spoke with the neurologist, but the neurologist did not order a substitute medication. NP #2 explained Resident #140 did not have any reported seizures or withdrawal symptoms while he was without Vimpat.

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During an interview with DON #1 on 9/16/22 at 10:45 AM, she indicated she was not working at the facility at the time the Vimpat was not provided to Resident #140. The DON stated Vimpat was not available in the medication backup system during June and July. There was not a way for Vimpat to be obtained for Resident #140 until it was dispensed by the pharmacy.

A follow up interview was conducted with NP #2 on 9/16/22 at 12:07 PM. NP #2 clarified she was made aware Resident #140 did not have his Vimpat in June 2022. She was not aware of the 3-day supply that was obtained in July 2022 and was not aware the resident was again without the medication after the 3-day supply ran out. NP #2 stated it took a week initially in June to contact the neurologist office regarding Resident #140's Vimpat. NP #2 was not aware the resident began receiving Vimpat in July 2022 as prescribed until she followed up with the nurse.

An interview was conducted with the Neurologist on 9/16/22 at 12:37 PM. She stated Nurse #6 notified the office that insurance would not cover Vimpat for Resident #140. On 6/24/22, the nurse requested an alternate medication. A prescription for the generic form of Vimpat was sent to the facility. The office nurse provided the facility with information regarding a patient medication assistance program. The Neurologist indicated the resident had been on Vimpat since being admitted to the facility 10/2020. Vimpat had been added to Resident #140's Depakote because he continued to have seizures while just being on Depakote. The neurologist explained it was not "ideal" for Resident #140 to only be on Depakote. She explained antiseizure medications should not

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be stopped abruptly or substituted with a different medication as seizures could occur. She was not aware of how long Resident #140 was without Vimpat. In July 2022, the resident's family member spoke with the office nurse and reported Resident #140 had not been receiving Vimpat at the facility.

The Administrator and Nurse Consultant were verbally notified of Immediate Jeopardy for F760 on 9/15/22 at 2:09 PM.

The facility provided a credible allegation of Immediate Jeopardy removal with a removal date of 9/17/22:

Removal Plan F760
1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

Vimpat was not administered as ordered on 6/26/22 - 7/10/22 and from 7/14/22 - 7/21/22. The medication was ultimately made available via generic medication order/ insurance authorization and after 7/21/22, the patient has received the medication.

The MD and one NP indicated Vimpat was a medication Resident #140 should not go without and he could have a seizure, end up in the hospital, and/or sustain serious harm as a result of a seizure. There was no harm or adverse effect on Resident #140. Resident was receiving other ordered seizure medications during the missed administrations of the Vimpat.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete;

The Assistant Director of Nursing (ADON) reviewed medication orders for all current residents receiving seizure medications to assure that medications were available on 9/15/22. No other anti-seizure medications were unavailable.

Education will be provided by 9/16/22 by the Director of Nursing, Staff Development Coordinator, or designee to all full time, part time, as needed, and contracted nursing staff (if applicable) on proper notification to providers, including Physician and NP, when a medication is unavailable. Staff not working on 9/16/22 will receive education prior to the start of their shift after 9/16/22.

The protocol would include, but not limited to the following:

1. receive clarification for a medication hold order, and/or

2. request alternative orders while original order is being processed or provided by pharmacy or while insurance authorization is being obtained.

3. Follow-up with the pharmacy to understand the cause of medication unavailability with immediate resolution.

4. Follow-up to internal provider (MD or NP) if specialist office is not available immediately for follow-up orders.

Alleged date of IJ removal is September 17th 2022.

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F 760	Continued From page 80 Person responsible for implementation is the administrator. The credible allegation was validated on 9/16/22 when staff interviews revealed that they had received recent education on processes when medications were unavailable, pharmacy notifications, addressing issues with insurance, when to have an authorization form completed, contacting the physician and nurse practitioner when medications were unavailable, and obtaining orders for medication substitutes when applicable. Facility documentation revealed staff were educated on issues related to medication availability. Review of the audit performed by the facility revealed all residents had their antiseizure medication available on the medication carts and the order listing report was used to verify this information. Date of IJ removal 9/17/22	F 760		
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.	F 812		11/2/22

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F 812	Continued From page 81 (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: Based on observations and staff interviews, the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. This practice had the potential to affect food served to all residents. Findings included: 1.During a kitchen tour on 9/12/22 at 9:33 AM, the following observations were made with the kitchen Supervisor: a. The walk-in refrigerator had dried frozen liquids under a black mat on the floor. There were food products and cups on the floor under the shelves. b. The walk-in freezer had frozen food products, ice cream cups and trash on the floor under the shelving where food was stored. The floor had frozen liquids under a black mat. c. The 9- stove burners had a heavy grease build up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills.	F 812	F812 1. All areas of the kitchen have been cleaned including food storage areas, food service equipment, grease buildup and dried food spills. 2. Current residents in the center have the potential to be affected. 3. Current Dietary employees educated by the Regional Dietary staff/designee on cleaning schedule and process for equipment in dietary department. Any dietary employee will not be allowed to work until education is received. Any new dietary employee will be educated by Dietary Manager or designee during the orientation process. 4. Dietary manager/designee to audit all equipment in kitchen for cleanliness weekly for 2 months, then monthly thereafter ongoingly. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Date of completion: 11/2/2022	

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d. The 4-compartment ovens had a heavy grease buildup, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where foods were being cooked. There was a dried grease buildup was observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven.

e. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. In addition, the fryer had heavy grease and food build up inside and outside, food products behind the fryer.

f. The 10 meal carts with dry food products stored in them had dried liquids, food crumbs and particles inside. The outside cart also had dried liquids running down the fronts/sides of the cart.

An interview was conducted on 9/12/22 at 9:50 AM, the Dietary Manager presented a checklist of the kitchen cleaning schedule. She stated staff were required to wipe down meal carts after each meal and deep clean carts weekly, oven/stove should be wiped down after each meal and deep cleaned weekly. The DM further stated she was responsible for ensuring the kitchen staff kept the equipment clean and orderly. She added the kitchen equipment should be wiped down daily and cleaned weekly in accordance with the kitchen cleaning checklist. The DM confirmed the identified meal cart and kitchen equipment had not been cleaned.

Follow-up observation on 9/13/22 at 8:00 AM, revealed the meal carts and kitchen equipment remained the same as the initial tour on 9/12/22.

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F 812	Continued From page 83 An interview was conducted on 9/14/22 at 10:00 AM, the Administrator stated the Dietary Manager was responsible for ensuring the kitchen was cleaned and maintained. The expectation would be for the Dietary Manager to ensure all kitchen cleaning protocols were in place and followed in accordance to with kitchen sanitation guidelines.	F 812		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, physician, nurse practitioner, respiratory therapist and Administrator interview the facility Administration failed to provide effective leadership and oversight of processes and policies and procedures to ensure an effective systems was in place. This impacted several residents including: Resident #46 where the facility failed to maintain a clear airway resulting in 5 trips to the Emergency Department. Resident #505 complained of respiratory distress at night with no medical attention provided. This resulted in requiring emergency medical services. Resident #505 was also sent to an outside appointment without oxygen resulting in respiratory distress. The facility failed to assure nursing staff were competent to provide necessary care to meet respiratory need for the residents including tracheostomy. Resident #140	F 835	F835 Administration # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The systems identified during this survey related to provision of services for tracheostomy care, oxygen therapies, and medication procurement were evaluated as part of this plan of correction by the facility administration: Administrator, Director of Nursing, and the governing body (Vice President of Operations, Regional Director of Clinical Services on 9/16/22. # - 2 Address how the facility will identify	11/2/22

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F 835	Continued From page 84 did not receive the prescribed Vimpat (antiseizure medication). The physician or nurse practitioner (NP) were not notified when antiseizure medication remained unavailable for Resident #140. This failure resulted in 3 of 3 residents to have Immediate Jeopardy level deficiencies for respiratory, competent staff, medication errors, and notification. The facility's failure resulted in Resident # 46 having 5 hospital admissions in 2 and a half weeks, Resident #505 being sent to the hospital for hypoxemia, and Resident #140 missing 45 doses of an anti-seizure medication which placed the resident at a high risk for seizure. The facility administration failed to provide and maintain documentation of annual updates and review of the facility ' s Emergency Preparedness Plan. This failure had the potential to affect all staff and residents. Immediate jeopardy began on 6/26/22 when the facility when the residents didn't have effective systems in place to provide necessary care and services for the residents. Immediate jeopardy was removed on 9/17/22 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put in place are effective. Findings include This is cross referenced to: F695 Based on observation, record review and interview of the staff, physician, Respiratory	F 835	other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the same deficient practice. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The governing body immediately assessed the effectiveness of leadership and management and systems to assure that residents needs are being met and necessary care and services are being provided effectively and competently. The Governing body consisted of: The facility Administrator, regional director of clinical services, VP of Operations and Chief Nursing Officer. The following action was taken based on that assessment: " The facility engaged in an agreement with a registered respiratory therapist (RTT), respiratory care practitioner (RCP). The contracted respiratory therapist (RTT), respiratory care practitioner (RCP) began on 9/16/22. His/her duties consist of: Weekly visits to monitor any resident□s requiring tracheostomy care, monthly visits to monitor resident□s receiving CPAP/BIPAP therapies. She/he will also be available as needed to address any issues related to respiratory care needs. " The facility□s pharmacy provider	

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F 835	Continued From page 85 Therapist, and resident, the facility failed to provide necessary respiratory care and services that met the need for Resident #46 to maintain a clear airway from tracheal secretions and frequent coughing which resulted in five trips in a two- and one-half week period of time to the Emergency Department (ED) to clear her airway and treat hypoxia. The facility failed to seek medical attention for Resident #505 when he complained of shortness of breath earlier in the night which resulted in low oxygen of 50% (out of 100%) by early morning. Emergency medical services were required, and a non-rebreather oxygen mask (high level oxygen flow) was needed and treatment at the Emergency Department. Resident #505 was also sent to an outside cardiology appointment without oxygen and was in respiratory distress for 2 of 2 residents reviewed for respiratory care. F726 Based on observations, record review and interviews of staff, contracted Respiratory Therapist, and Medical Director, the facility failed to train nursing staff and verify competency to provide for and to meet the respiratory care needs for 1 of 1 resident reviewed for tracheostomy care. Resident #46 required 5 trips to the Emergency Department (ED) over a two and a half week period of time to clear her airway and treat hypoxia as a result of staff not maintaining a clear airway from tracheal secretions. F760 Based on record review, staff interviews, family interview, pharmacist interview, and physician interviews, the facility failed to provide prescribed antiseizure medication for 1 of 10 residents (Resident #140) reviewed for medication errors. Resident #140 did not receive	F 835	offers resources, such as the Customer Service Representative, Regional Director of Customer Success, and Vice President of Customer Success available to the facility 24/7, related to medication availability concerns. " Current nursing leadership to include Director of Nursing, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) received education with return demonstration on 9/16/22 by the center respiratory therapist regarding trach care to include: tracheostomy care, frequency of suctioning and reassessment of resident□s oxygen status and need for re-suctioning, respiratory assessment, and documentation of such care, as well as caring for patients with c-paps, bi-paps, and oxygen while in center and preparing for external appointments. " A new licensed Administrator was hired and started on 9/29/22 and a new Director of Nursing hired with a start date of 10/17/22. " New medical directorship occurred as of 10/1/22. " Through monthly meetings and periodic reports, the Administrator maintains an ongoing liaison with the governing body, medical and nursing staff of the facility. He/she acts upon recommendations made by the governing body□s committees. The Administrator effectively channels and communicates the strategic plans to his or her management team through weekly manager meetings. " The facility will continue to identify and monitor the effectiveness of resources to	

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F 835	Continued From page 86 prescribed Vimpat (antiseizure medication) from 6/26/22 - 7/10/22 and from 7/14/22 - 7/21/22. This resulted in the resident not receiving 45 doses of antiseizure medication. F580 Based on record review, staff interviews, and physician interviews, the facility failed to notify the physician or nurse practitioner (NP) when antiseizure medication remained unavailable for Resident #140, pain medication was unavailable for Resident #42, and when the nurse was unable to obtain intravenous (IV) access for Resident #111 to provide hydration as ordered for 3 of 4 residents reviewed for notifications (Resident #140, Resident #42, and Resident #111). E004Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual updates and review of the facility ' s Emergency Preparedness Plan. This failure had the potential to affect all staff and residents. During an interview 9/16/22 at 1:45 PM, the Administrator indicated she was an interim administrator and was hired in August. She indicated she had recently conducted the quality assurance (QA) meeting on 9/15/22. The identified concerns were discussed in the QA meeting. During an interview on 9/16/22 at 1:48 PM, Regional Director of Clinical Services she stated she was hired in August of 2022. She tried to be on-site once a week and while on site, she would attend morning and clinical meetings. A 24 or 72 hour look back review was completed for any concerns reported in the meetings. The Regional	F 835	care for its residents competently during both day-to-day operations and emergencies using the facility wide assessment per ¿483.70(e) Facility assessment guidance. " The facility will continue to maintain updates and review the Facility□s Emergency Preparedness Plan annually and as needed. " The Leader of the governing body (VP of Operations) engaged into a contract with an outside Clinical Consulting Company on 9/24/2022 to provide oversight with the plan of correction process, oversee implementation of the plan of correction, auditing and ongoing follow up of the plan of correction. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. " Monitoring will occur by review of each specific area of non-compliance monitoring results (F580 Physician notification, F695 Respiratory Care, F726 Nursing Competence, F760 Medication Error, E004 Emergency Preparedness Plan) presented to the Quality Assurance Improvement Committee monthly. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. " The governing body will continue to oversee implementation of education, auditing and ongoing follow-up of this	

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F 835	Continued From page 87 Director of Clinical Services further stated a weekly report from the Director of Nursing (DON) was reviewed and follow up meeting done for repeated concerns. The DON was educated on repeated concerns, and monitoring tools were put in place. The DON and Administrator could contact the Regional Director of Clinical Services at any time. Regional Director of Clinical Services stated since her hire, she was not involved in QA meeting and moving forward would be involved with QA meetings. The Regional Director of Clinical Services further stated the facility now has a respiratory therapy on board to provide good care for residents with respiratory care needs. On 9/15/2021 at 5:15 PM, the administrator was informed of the immediate jeopardy. The allegation of immediate jeopardy removal indicated: Credible Allegation of Immediate Jeopardy removal: F835 - Administration Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance The facility Administration failed to provide effective oversight and leadership to ensure respiratory care needs were met, staff were trained and competent to provide necessary care and services to meet respiratory needs of residents, provide anti-seizure medications, provide physician notification of medications not administered for residents #46, #505 and #140.	F 835	credible allegation, with visits no less than twice weekly, until such time full compliance is obtained beginning 9/17/22. The governing body asserts that the Regional Directors of Clinical Services are BSN trained, with competence in the areas of respiratory, pharmacy, and staff competencies. The Chief Nursing Officer will oversee them directly, and the governing body asserts she is credentialed as a Registered Nurse, Master of Health Administration and is also a Licensed Nursing Home Administrator, and is competent to oversee the Directors of Clinical Services. " Contracted Nurse Consultants will also provide oversight and monitoring with written feedback and recommendations as needed. Date of completion: 11/2/2022	

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

The individual responsible for this education is a registered respiratory therapist (RTT), respiratory care practitioner (RCP). The contracted RTT, RCP began on 9/16/22, and will be here weekly to monitor the trach patient, with monthly visits to review CPAP/BIPAP patients ongoingly. She will also be available as needed to address any issues related to respiratory care needs.

The center's pharmacy provider has resources available, such as the Customer Service Representative, Regional Director of Customer Success, and VP of Customer Success available to center administration 24/7, related to medication availability concerns.

The systems identified during this survey related to provision of services for trach care, oxygen therapies, and medication procurement were evaluated as part of this plan of correction by center administration, corporate leadership and the governing body on 9/16/22.

Alleged date of IJ removal is 9/17/22.

Person responsible for implementation is the administrator.

on 9/19/22 at 4:55 PM an interview was conducted with the Administrator and Corporate Nurse Consultant. The Administrator stated a contracted Respiratory Therapist was hired on 9/16/22. The Administrator further stated the Respiratory Therapist would return to the facility

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F 835	Continued From page 89 each week to monitor trach residents and residents with CPAP and BiPAP monthly and as needed ongoing. The Administrator stated she was aware the current medication pharmacy provider was sending medication late and the medication was not available. The Administrator stated the center's pharmacy provider would provide resources needed to address when medication were unavailable. Medication substitutions would be to address issues related to mediation unavailability and the physician would be notified immediately for medication replacement. The Administrator indicated training to all agencies staff had been added to the QAPI plan. All identified concerns in each area were evaluated on 9/16/22. The Administrator indicated a new Medical Director was also hired and would assist to address care issues related to medication unavailability.	F 835		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		11/2/22

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(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.

§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;

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F 842	Continued From page 91 (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, staff interviews and record review, the facility failed to maintain accurate documentation in the Medication Administration Record (MAR) for 2 of 10 residents reviewed for accurate medication administration documentation (Resident #140 and Resident #42). Nurses documented on the MAR Resident #42's pain patch as administered when it was not available and Resident #140's antiseizure medications as administered when it had not been dispensed. The findings included: 1. Resident #140 was admitted to the facility on 10/12/20. Diagnoses included epilepsy (seizure disorder) and Wernicke's encephalopathy (degenerative brain disorder). Resident #140 was initially ordered Vimpat on 10/12/20. The order dated 5/27/22 revealed Vimpat 200 milligrams (MG) give one tablet by mouth two times a day for seizures, controlled substance. Review of controlled substance records revealed nurses administered Vimpat to Resident #140 until 6/26/22 when the medication became unavailable. The resident did not receive	F 842	F842 1. Resident #42 and Resident # 140 are now receiving their medications as ordered. Education was provided for Nurse # 16, 17, 19,27 and #9 was educated on the 5 R(s) of medication administration and accurately documenting the administration of medications on the EMAR. 2. Current Residents in the center who receive medications have the potential to be affected. 3. Current Licensed Nursing Staff will be educated by SDC/DON or designee on appropriately documenting medication as given process for documentation when medication is not available Any licensed nurse not receiving education will not be allowed to work until education is received Any new licensed nurse will educated by SDC/DON or designee during the orientation process 4. DON or designee will perform 25 resident MARs audits for medication availability audit weekly for 2 months and then at least 25 residents monthly for 4 months to ensure compliance. Results of	

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F 842	Continued From page 92 prescribed Vimpat from 6/26/22 - 7/9/22 or from 7/14/22 - 7/21/22. Resident #140 received Vimpat from 7/10/22 - 7/13/22 when a 3-day emergency supply had been authorized and dispensed to the facility by the pharmacy. Nurse #16 documented Vimpat was administered to Resident #140 at the following dates and times when the medication was unavailable: 6/27/22 at 9:00 PM, 6/30/22 at 9:00 PM, and 7/14/22 at 9:00 PM. An attempt to interview Nurse #16 on 9/16/22 was unsuccessful. Nurse #17 documented Vimpat was administered to Resident #140 at the following date and time when the medication was unavailable: 6/28/22 at 9:00 PM. An attempt to interview Nurse #17 on 9/16/22 was unsuccessful. Nurse #19 documented Vimpat was administered to Resident #140 at the following dates and times when the medication was unavailable: 6/29/22 at 9:00 PM, 7/19/22 at 9:00 PM, and 7/21/22 at 9:00 PM. An attempt to interview Nurse #19 on 9/16/22 was unsuccessful. Nurse #27 documented Vimpat was administered to Resident #140 at the following dates and times when the medication was unavailable: 7/1/22 at 9:00 AM and 7/6/22 at 9:00 AM. Nurse #9 documented Vimpat was administered to Resident #140 at the following date and time	F 842	the audits will be reviewed at Quarterly Quality Assurance Meeting for further resolution if needed. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting x 2 for further resolution if needed. Date of completion: 11/2/2022	

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when the medication was unavailable: 7/19/22 at 9:00 AM.

During an interview with Nurse #9 on 9/16/22 at 10:38 AM, she stated she did not recall if the medication was administered on 7/19/22.

An interview was conducted with the Regional Director of Clinical Services #1 on 9/14/22 at 2:57 PM. She stated administration documentation for Resident #140's Vimpat was unclear, and the facility had issues with documentation. She did not know if the nurses accurately documented Resident #140's medication administration.

During an interview with the Director of Nursing #1 (DON) on 9/16/22 at 10:54 AM, she stated Vimpat was not available in the medication backup system in June and July. DON #1 indicated there was not a way for Vimpat to be obtained and administered for Resident #140 until it was dispensed by the pharmacy. She stated nurses were expected to accurately document medication administration for residents.

2. Resident #42 was readmitted to the facility on 6/15/21. Diagnoses included arthropathy (disease of joints) and polyosteoarthritis (joint pain and swelling).

Resident #42 was ordered Salonpas, an over-the-counter pain relief patch, on 5/25/22. It was to be applied to the left shoulder daily.

On 8/20/22, Nurse #12 documented on the MAR she administered a Salonpas pain patch for Resident #42. A progress note dated 8/20/22, however, indicated the medication was not given, stating the resident's medication was unavailable.

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F 842	Continued From page 94 Attempts to interview Nurse #12 on 9/13/22 were unsuccessful. During an interview with Nurse #6 on 9/14/22 at 10:35 AM, she stated she was aware the Salonpas patches were not administered to Resident #42 on 8/20/22 and 8/21/22. Nurse #12 informed her the patches were unavailable on those days. Nurse #6 asked Nurse #12 to get an order for an alternate medication. It was unknown if Nurse #12 called the physician. During an interview with the Assistant Director of Nursing (ADON) on 9/15/22 at 2:41 PM, she confirmed Nurse #12 documented the Salonpas patch was administered on the MAR on 8/20/22, but the progress note indicated the patch was not available to be administered.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification survey dated 7/31/19 and complaint surveys dated 11/16/20, 4/6/21, 10/11/21, 12/31/21, and 3/31/22 in order to achieve and sustain compliance. This was for	F 867	F867 1 The facility failed to initiate a Quality Assurance Program to implement, monitor and revise action plans 2. Current Residents in the center have the potential to be affected. 3. Current QA committee was in serviced by Regional Director of Clinical	11/2/22

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	345420	A. BUILDING _____ B. WING _____	C 09/19/2022

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F 867	Continued From page 95 recited deficiencies on a recertification survey on 9/19/22. The deficiencies were in the area of notification of changes, accuracy of assessments, activities of daily living care, treatment /services to prevent/heal pressure ulcers, sufficient nursing staff, Pharmacy services and procedure, Administration, and resident records-identifiable information. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F 580: Based on record review, staff interviews, and physician interviews, the facility failed to notify the physician or nurse practitioner (NP) when antiseizure medication remained unavailable for Resident #140, pain medication was unavailable for Resident #42, and when the nurse was unable to obtain intravenous (IV) access for Resident #111 to provide hydration as ordered for 3 of 4 residents reviewed for notifications (Resident #140, Resident #42, and Resident #111). During the previous complaint survey on 3/31/22 the facility failed to notify the resident's representative about the changes in medication administration regimen for Zyprexa (antipsychotic) for 1 of 1 resident reviewed for notification (Resident #6). Complaint investigation on 12/13/21 the facility failed to notify the physician when a resident refused two consecutive hemodialysis procedures for 1 resident; failed to notify the physician when	F 867	Services/designee on the QA process including implementation, monitoring, and revising the action plan as required to maintain compliance 4.Monitoring of all cited deficiencies tools including F580, F641, F 677, F686, F 726, and F755 will be reviewed by Governing Body which includes the Regional Director of Clinical Services and Regional VP of Operations. This will be an ongoing process to ensure compliance. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting x 2 for further resolution if needed. Date of completion: 11/2/2022	

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medication was unavailable for administration for 4 days, for 1 resident, who missed 13 doses of medication. The failure of notification occurred for 2 of 3 residents reviewed for notification (Resident #10 and 14).

2. F641: Based on observations, staff interviews and record reviews, the facility failed to accurately code wandering behavior, a prognosis of less than six months, pain, and activities of daily living on the Minimum Data Set (MDS) assessments for 4 of 40 residents (Residents #58, #64, #42 and #98) reviewed for MDS accuracy.

During the previous Complaint survey on 12/13/21 the facility failed to accurately code Activities of Daily Living (ADL) on the Minimum Data Set (MDS) assessment for 1 of 14 residents reviewed for ADL's (Resident # 14).

Complaint survey on 11/16/20 the facility failed to conduct a skin assessment to accurately document a resident's skin condition on the Minimum Data Set (MDS) Assessment for 1 of 1 resident assessment reviewed. (Resident #1)

During the recertification and complaint survey on 7/31/19 the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect a significant weight loss for 1 of 9 residents (Resident #101) reviewed for Nutrition.

3. F677: Based on observation, record review and interviews with resident, and staff, the facility failed to provide incontinence care (Resident #75) and failed to provide personal hygiene and grooming (Resident #355) for 2 of 15 dependent residents reviewed for ADL care.

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During the previous complaint survey on 10/11/21 the facility failed to provide baths and showers for two (Resident #3 and Resident #4) of three dependent residents reviewed for the provision of assistance with activities of daily living.

4. F686 - Based on observation, record review, and interview of staff and resident, the facility failed to follow the pressure ulcer dressing order and used saline instead of wound cleanser and placed the wrong medication in the wound bed (Resident #131) for 1 of 3 residents reviewed for pressure ulcer.

During the previous complaint survey on 12/13/21 the facility failed to perform skin assessments to monitor or identify skin concerns for 2 (Residents #1 and #2) of 3 residents reviewed for pressure ulcer/wound care. Resident # 1 was assessed by the hospital to have a severe unstageable spine decubitus ulcer.

Complaint investigation on 11/16/20 the facility failed to assess the sacral wound, failed to accurately document the hospital transfer form for a sacral ulcer for 1 of 3 residents assessed to be at high risk for pressure ulcers. (Resident #1).

5. F726 - Based on observations, record review and interviews of staff, contracted Respiratory Therapist, and Medical Director, the facility failed to train nursing staff and verify competency to provide for and to meet the respiratory care needs for 1 of 1 resident reviewed for tracheostomy care. Resident #46 required 5 trips to the Emergency Department (ED) over a two and a half week period of time to clear her airway and treat hypoxia as a result of staff not maintaining a clear airway from tracheal

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secretions.

During the previous complaint survey on 12/13/21 the facility failed to train an agency nurse how to put new admission orders into the electronic medical record for 1 (Nurse #23) of 2 nurses reviewed for knowledge of the electronic medical record system.

6. F755 - Based on Based on record review, staff interviews, pharmacist interview, and Physician interview, the facility failed to provide access to over-the-counter pain patches (Salonpas pain relief patch) for a resident with joint pain (Resident #42) resulting in two missed doses of the pain medication. This occurred for 1 of 10 residents reviewed for pharmacy services.

During the previous Complaint survey on 12/13/21, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 3 residents (Resident # 1). Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on 9/1/2021. The cause of death of Resident #1 was determined to be septic shock.
The facility failed to obtain pain medication from the pharmacy which delayed medication administration for 1 of 2 residents (Resident #14) reviewed for pain.

Complaint investigation on 4/6/21, the facility failed to follow facility pharmacy procedures for receiving controlled substances. Staff did not check the delivered medication, sign the delivery manifest, fax it to the pharmacy or immediately log the accepted Hydrocodone-Acetaminophen, a

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controlled substance, into the facility's-controlled medication inventory system. Two staff did not verify and count and then store the controlled substance according to the facility's Pharmacy Services and Procedure Manual. This failure involved four of four nurses who worked on 2/11/21 (Nurse #1, Nurse #2, Nurse #3 and Nurse #4).

7. F835 Based on record review, staff interviews, physician, nurse practitioner, respiratory therapist and Administrator interview the facility Administration failed to provide effective leadership and oversight of processes and policies and procedures to ensure an effective systems was in place. This impacted several residents including: Resident #46 where the facility failed to maintain a clear airway resulting in 5 trips to the Emergency Department. Resident #505 complained of respiratory distress at night with no medical attention provided. This resulted in requiring emergency medical services. Resident #505 was also sent to an outside appointment without oxygen resulting in respiratory distress. The facility failed to assure nursing staff were competent to provide necessary care to meet respiratory need for the residents including tracheostomy. Resident #140 did not receive the prescribed Vimpat (antiseizure medication). The physician or nurse practitioner (NP) were not notified when antiseizure medication remained unavailable for Resident #140. This failure resulted in 3 of 3 residents to have Immediate Jeopardy level deficiencies for respiratory, competent staff, medication errors, and notification. The facility's failure resulted in Resident # 46 having 5 hospital admissions in 2 and a half weeks, Resident #505 being sent to the hospital for hypoxemia, and Resident #140

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missing 45 doses of an anti-seizure medication which placed the resident at a high risk for seizure.

During the previous Complaint survey on 12/13/21, the facility Administration failed to provide effective leadership and oversight of processes and policies and procedures to ensure an effective system was in place to implement medication orders for new admissions for one (Resident #1) of three new admissions; failed to have an effective system in place for new admission medication reconciliation for one (Resident #1) of three new admissions; failed to have an effective system in place for comprehensive pharmacy reviews for one (Resident #1) of three residents with pharmacy reviews. The facility Administration also failed to perform a root cause analysis for the medication errors and implement systematic changes to prevent additional medication errors from occurring until immediate jeopardy was identified for one (Resident #1) of three new admissions. The facility Administration failed to have an effective, comprehensive approach to responding to acute/significant changes in condition to ensure necessary care and services were provided for 1 (Resident #1) of 1 resident reviewed for neglect. Resident #1 received 29 incorrect medications for a period of 8 days. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on

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9/1/2021. The cause of death of Resident #1 was determined to be septic shock.

8. F842 - Based on Based on observations, staff interviews and record review, the facility failed to maintain accurate documentation in the Medication Administration Record (MAR) for 2 of 10 residents reviewed for accurate medication administration documentation (Resident #140 and Resident #42). Nurses documented on the MAR Resident #42's pain patch as administered when it was not available and Resident #140's antiseizure medications as administered when it had not been dispensed.

During the previous Complaint survey on 12/13/21, the facility failed to accurately document the provision of wound care on the Treatment Administration Record for 2 (Residents #2 and Resident #11) of 3 residents reviewed for the provision of wound care.

During an interview on 09/16/22 04:13 PM, the administrator stated she was an interim administrator and had joined the facility in August 2022. The administrator stated the citations would be reviewed and a plan of correction would be put in place. The administrator indicated she had conducted a QAA meeting on 9/15/22 and identified issues were discussed in the meeting. Administrator stated the Quality Assurance (QA) committee does 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System change and addition task would put in place as needed to resolve the issue. The team would continuously monitor until the deficient area concerns have been resolved.