| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PENICK VILLAGE | 401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and facility reported incident investigation survey was conducted on 10/22/23 through 10/24/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #891111. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification and facility reported incident investigation survey was conducted on 10/22/23 through 10/24/23. The following intake was investigated NC00208466.<br><br>1 of 1 FRI did not result in a defciency. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and interviews, the facility failed to provide care in a safe manner which resulted in a fall from the bed for 1 of 5 residents reviewed for accidents (Resident #19).<br><br>Findings included:<br><br>Resident #19 was admitted to the facility on 11/24/2020 with diagnoses that included Alzheimer's disease. | F 689 | F689:<br>Corrective action taken regarding resident affected by deficient practice: On 5/11/2023, Resident #19 fell out of bed during care and sustained a laceration to her head. The c.n.a. informed the charge nurse who assessed the resident, provided first aid. Education was completed by the DON to have supplies readily accessible and to turn resident | 11/10/23 |

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

Electronically Signed | 11/08/2023

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| F 689 | Continued From page 1<br><br>Review of quarterly Minimum Data Set (MDS) dated 10/9/2023 indicated the resident was severely cognitively impaired, nonverbal, rarely understood others, and rarely understood by others. Resident #19 was totally dependent upon staff for all activities of daily living, toileting, and personal hygiene.<br><br>A review of Resident #19's care plan, last reviewed 9/14/2023, contained a focus for risk of decline in ability to perform self-care related to Alzheimer's dementia, osteoarthritis and debility. Interventions included the resident was total care for bed mobility. The intervention was dated 8/10/2021. The resident had additional interventions that included total assist for any toileting, incontinent care, and brief changes, related to incontinence of bowel and bladder. Resident #1 also had a focus for risk of injury from falls related to decreased safety awareness and impulsivity secondary to my cognitive impairment, weakness, balance issues, and need for assistance with mobility and self-care.<br><br>Review of the incident report dated 5/11/2023 indicated Resident #19 fell out of the bed during incontinent care by Nurse Assistant (NA) #1. The resident sustained a superficial laceration (1.5 centimeters in length) to her head during the fall. The resident was assessed by Nurse #2 prior to being moved from the floor to the bed. The resident's Responsible Party (RP), the Medical Director (MD), and the Director of Nursing (DON) were notified of the fall. The resident was placed on neurological checks and frequent observation.<br><br>Review of nursing progress note dated 5/11/2023 | F 689 | towards staff not away. Corrective action taken regarding those residents with the potential to be affected: An audit was completed on all residents that had fallen within the past 6 months that the root cause identified as not having items in reach or not following safety best practices such as repositioning residents away from staff. This audit was completed by the DON on 10/26/2023. To prevent this from reoccurring, all nursing staff educated by RN Supervisor on how to provide resident care while ensuring resident safety (roll resident towards staff or have second staff member provide assistance) on 10/25/2023. Any licensed or nursing staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency licensed nurses or nursing staff and newly hired licensed nursing or nursing staff will have this education during their orientation. We are utilizing a new fall risk assessment on admission that calculates a score to determine if an immediate intervention needs to be placed. Monitoring Compliance: To monitor and maintain ongoing compliance, the RN Supervisor or Designee will review all falls for root cause to ensure that safety techniques were performed by the staff member and that an immediate fall prevention intervention has been implemented by the licensed nurse. The IDT team will review the fall report in morning clinical meeting along with prior interventions in place if applicable for appropriateness. This monitoring will | |

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| F 689 | Continued From page 2<br>indicated the RP did not want the resident sent to the Emergency Department (ED). The resident's bed was placed in a low position and the resident remained on frequent observation.<br><br>On 10/24/2023 at 9:00AM an attempt to interview the resident was unsuccessful. Resident #19 did not respond to writers questions.<br><br>On 10/24/2023 at 10:52 a phone interview was conducted with NA#1. She stated she was performing incontinent care alone and turned the resident on her side. When she turned to grab an incontinent brief from the bedside table, the resident rolled away from her. She could not catch her before she slid off the opposite side of the bed. She stated she yelled out for help and Nurse #2, who was assigned to Resident #19 at that time, came into the room. Nurse #1 assessed the resident, and three staff members placed the resident back into the bed. She stated the resident was bleeding from her head. NA #1 stated she was familiar with Resident #19 and had performed incontinent care on her many times in the past without assistance. She was not sure if she had the resident positioned too far away from her or it happened because she let go of the resident to reach for the incontinent brief. NA#1 stated she was provided education by the DON on having all supplies within reach prior to beginning incontinent care and on turning the resident toward you and not away from you to prevent falls.<br><br>On 10/24/2023 atv11:00 AM a phone interview was conducted with Nurse #2. She stated she heard NA#1 yell out from Resident #19's room. When she entered the room, she observed Resident #19 on the floor between the bed and | F 689 | remain in place. The Director of Nursing or Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. | |

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| F 689 | Continued From page 3<br>the wall. The resident was bleeding from her head. Once she assessed the resident, three staff placed her back into the bed. Nurse #2 asked NA#1 what happened. NA#1 told her she turned the resident away from and took her hand off her briefly to grab an incontinent brief off the bedside stand and the resident rolled off the bed. The nurse stated the resident was typically provided incontinent care by one staff and not two. Nurse #2 stated she called the MD, the RP, and the DON to make them aware of the fall. The RP did not want the resident sent out to the Emergency Department for a superficial laceration. The resident was placed on increased observation and the MD gave orders to clean and cover the superficial laceration on her head.<br><br>During an interview with the DON on 10/24/2023 at 4:00PM. Stated the resident was 1-2 staff assistance with incontinent care at the time of the incident. The facility provided education to staff regarding how to maintain safety while providing care to include having all supplies within reach and turning resident toward caregiver and not away. | F 689 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals | F 761 | | 11/10/23 |

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| F 761 | Continued From page 4<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to date multi-use medications per manufacturer's recommendations upon opening in 1 of 1 medication cart (station 2 medication cart) reviewed for medication storage and labeling.<br><br>Findings included:<br><br>An observation was conducted on 10/22/23 at 11:21 AM of the medication cart at station 2 in the presence of Nurse #1. The observation revealed no opened date on the following multi-dose medications:<br><br>1. One multi-dose 10ml bottle of lubricant 0.4%-0.03% solution eye drops. (Manufacturer's recommendation to discard 90 days after opening).<br><br>2. One multi-dose 10ml bottle of Lumigan Sol | F 761 | F761<br><br>REVISED:F761<br>Corrective action taken for affected resident: On 10/22/23, the charge nurse removed the multi-dose medications that were not dated from the cart and discarded the medication. Corrective Action taken for those residents with the potential to be affected: All medication carts were audited and any multi-dose medication found not dated were removed from the cart and discarded by licensed charge nurse. To prevent this from reoccurring: On 10/23/2023 the RN Supervisor completed education with all current nursing staff regarding the requirement to date multi-dose medications when opening. Any licensed or nursing staff that cannot be reached within the initial reeducation time frame, | |

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| F 761 | Continued From page 5<br>0.01% solution eye drops. (Manufacturer's recommendation to discard 4 weeks after opening).<br><br>3. One multi-dose package of Ipratropium Bromide and Albuterol Sulfate 0.5 milligram (mg)/3mg per 3 milliliter (ml) inhalation vials.<br><br>Nurse #1 confirmed the medications were not dated and she removed them from the medication cart and discarded them. She indicated nurses were to write the date on all multi-dose medications upon opening and check dates prior to administration. She stated she did not realize they were not dated. She also stated that the pharmacy consultant checks medication carts for undated medications monthly.<br><br>An interview was conducted with the Director of Nursing (DON) on 10/24/23 at 3:45 PM. She stated it was the nurse ' s responsibility to date multi-dose medications upon opening and they should be checking for dates daily prior to administration. | F 761 | will not take an assignment until they have received this reeducation. Agency licensed nurses or nursing staff and newly hired licensed nursing or nursing staff will have this education during their orientation. Monitoring Compliance: Medication carts will be audited weekly x 4 weeks, then 1x every 2 weeks x 3 months by the RN Supervisor any issue identified will be corrected immediately by RN Supervisor. Medication carts will be reviewed monthly by the Consultant Pharmacist and Pharmacy Nurse Consultant with any medication found not dated removed immediately and the Director of Nursing notified. The Director of Nursing or Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input | F 867 | | 11/10/23 |

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| F 867 | Continued From page 6 | F 867 | | |

from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

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| F 867 | Continued From page 7<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).<br>Improvement projects must include at least annually a project that focuses on high risk or | F 867 | | |

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| F 867 | Continued From page 8<br>problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey conducted on 07/28/21, 08/10/22 and during a complaint investigation on 08/23/23. This was for 1 deficiency that was cited in the area of Free of Accident Hazards/Supervision/Devices. The deficient practice area was recited on the current recertification and complaint survey of 10/24/23. The duplicate citation during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective QAPI program. | F 867 | F867<br>All residents have the potential to be affected by un-sustained QAPI A QAPI meeting was completed on 10/30/31 to review deficiencies. The interdisciplinary team was educated by the VP of Clinical services to ensure an effective QAPI meeting is completed monthly on 8/10/23. New department heads will be educated by the VP of Operations during the orientation process. The VP of Operations will ensure an effective QA meeting and compliance with plan of correction is completed monthly for 3 months. Results of these audits will be presented by the Director of Nursing to the facility Quality Assurance and Performance | |

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| F 867 | Continued From page 9<br>The findings included:<br><br>This citation is cross referenced to:<br><br>F689-Based on record review and staff and interviews, the facility failed to provide care in a safe manner which resulted in a fall from the bed for 1 of 5 residents reviewed for accidents (Resident #19).<br><br>During a complaint investigation on 08/23/23, the facility failed to safely transfer a resident from her bathroom to the recliner using the mechanical lift that resulted in the dislocation of the left shoulder which required treatment at a hospital. The facility also failed to safely transfer a resident from her motorized wheelchair to the bed using the mechanical lift that resulted in a fracture to the right hip which required treatment at a hospital. This was for 2 of 6 residents reviewed for supervision to prevent accidents.<br><br>During the facility's recertification survey of 08/10/22, the facility failed to identify the root cause and implement effective interventions to prevent multiple falls for a resident. In addition, the facility failed to identify the root cause for multiple falls for another resident and failed to safely utilize a total body (hydraulic lift utilizing a body sling) lift while attempting to transfer a resident resulting in a fall without injuries for a third resident. This was for 3 of 3 residents reviewed for accidents.<br><br>During the facility's recertification survey of 07-28-21, the facility failed to determine the root causes of each fall and put effective interventions in place following each fall to prevent repeated falls for 1 of 5 sampled residents reviewed for | F 867 | Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. | |

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| F 867 | Continued From page 10<br>falls.<br><br>An interview was conducted with the Director of Nursing (DON) and Infection Control (IC) Nurse on 10/24/23 at 3:54 PM. They both stated they felt the repeat citation was the result of miscommunication between Penick Village nursing staff and agency staff. They also stated they had recently changed their approach to the accidents Performance Improvement Project (PIP). | F 867 | | |