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F 000	INITIAL COMMENTS The surveyor entered the facility on 1/22/24 to conduct a complaint investigation and exited on 1/25/24. Additional information was obtained on 1/26/24. Therefore, the survey exit date was changed to 1/26/24. The following intakes were investigated NC 00211651; NC 00207302; NC 00212138; NC 00206740; NC00208545; and NC208689. Four of the eighteen complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		2/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/15/2024

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

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews, the facility failed to ensure repairs for cracks, holes, a water damaged wall, broken blinds, and discolored flooring were completed for two (Residents # 6 and # 7) of two residents reviewed for environmental concerns and for two random rooms. The findings included. 1a. Resident # 7 was admitted to the facility on 10/18/22. The resident's 1/3/24 quarterly MDS (Minimum Data Set) assessment coded the resident as having moderate cognitive impairment. According to Resident # 7's record, she had resided in the same room since 8/8/23. Resident # 7's room was observed on 1/22/24 at 10:35 AM and the following observations were made. The resident's AC/Heating unit was one which was installed through the wall. Around the	F 584	F584- Safe/Clean/Comfortable/Homelike Environment: Resident #7 wall was repaired by the Maintenance Director on 2-13-24. Resident #7 Space around PTAC unit was repaired by the Maintenance Director on 2-15-24. Resident #7 blind was replaced on 2-15-24. Room #234 two holes above the bed were repaired on 2-13-24. Room #232 floor will be repaired on 2-21-24. Resident #6 hole in bathroom door was repaired on 2-15-24. A quality review was completed by the Maintenance Director and Executive Director to assess walls, space around PTAC units, broken blinds and floor damage on 1-31-24. An ADHOC Quality Assurance Performance Improvement	

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unit, a large part of the wall was filled with plaster which had not been smoothed off or painted. Two slats were broken on her blinds. Resident # 7 stated the wall and blinds had been like that since she had moved into the room. She felt no one could see her through the broken blinds because the broken part was closer to the foot of the bed than the head of the bed.

The Maintenance Director was interviewed on 1/23/24 at 11:20 AM and observations of Resident # 7's room was shared with him. The Maintenance Director reported the following. He had begun his employment in September 2023, and Resident # 7's wall was like it was currently when he arrived in September 2023. The previous Maintenance Director had not left a list of things that needed to be addressed. He (the current Maintenance Director) was trying to identify and correct things. The wall in Resident # 7's room had had water damage. The previous Maintenance Director had done the wood plaster and left it like it currently was. He (the current Maintenance Director) had not had time to address her wall as of yet.

1b. During a random observation of Room 234 on 1/23/24 at 8:25 AM it was noted there were two holes in the wall above the head of the bed. The holes appeared to be approximately 6 inches long with approximately an inch width. At the time, there was a resident residing in the room who was unsure how long the holes had been there. At the time of the observation, the outside temperature was cold on 1/23/24. (The facility had signs posted in the hallway on 1/23/24 which directed that due to extremely low temperatures all faucets were to remain on to ensure no water froze in the pipes.) During the random

F 584

Committee was held on 1-31-24 to formulate and approve a plan of correction for the deficient practice.

The Executive Director educated the Maintenance Director and Maintenance Assistant on ensuring wall repair, space around PTAC units, replacing broken blinds and floor damage repaired on 1-31-24. Department managers and staff educated on documenting on maintenance log when identifying anything maintenance related not working properly or any wall, floor, blinds or space around PTAC noted needing repaired by the Executive Director/Maintenance Director by 2-21-24.

The Executive Director will conduct random Quality reviews by observation of 5 resident’s rooms to ensure walls, space around PTAC units identified, blinds and floors are in good repair and 5 residents’ rooms to ensure walls are in good repair 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Resident #6 specific concerns in regards to the AC/Heat unit was resolved and the hole underneath the unit was repaired on 2/15/24.

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observation of Room 234, cold air movement could be felt coming through the holes in the wall.

On 1/23/24 at 8:40 AM the Administrator was asked to view the holes with the surveyor. The Administrator reported he had not been alerted there was a problem and stated he would check into the situation.
On 1/23/24 at 10:50 AM the Administrator reported he had spoken to the Maintenance Director who had said he did not have the patch to do the wall.

On 1/23/24 at 11:20 AM the Maintenance Director was interviewed and reported the following. There had been a piece of railing board on the wall at the head of the bed. The paint was chipping off and it did not look good. On Friday (1/19/24) he had pulled the railing board off the wall. He had not been aware there were anchor bolts for the railing board into the wall. When the railing board was removed, it left the holes where the anchor bolts had been. He did not have enough patch to cover the holes. He had ordered the patch, but it was back ordered. Originally, it was back ordered for 5 days and then 13. After the Administrator talked to him after viewing the holes with the surveyor, the Administrator had told him to go to a local store and obtain wall patch.

The Administrator was interviewed on 1/25/24 at 2:35 PM and reported if he had been notified of the inability to patch the wall because of materials, he would have told the Maintenance Director to go to the local store when the need first arose.

1c. During a random observation of Room 232 on 1/22/24 at 10:02 AM, it was observed that the

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floor stood out as very discolored. There were patches of gray discoloration scattered throughout the flooring.
On 1/23/24 at 11:20 AM the Maintenance Director was interviewed and reported the following. He was aware of the discoloring. He felt the floor tiling needed to be replaced in Room 232 because it was "worn out." There was no wax on the floor and he did not feel stripping it would help the problem.

1d. Resident # 6 was admitted to the facility on 2/3/22. Resident # 6's annual Minimum Data Set assessment, dated 1/7/24, coded the resident with moderate cognitive impairment. The resident was interviewed on 1/22/24 at 10:10 AM and indicated he was concerned with any cracks in his room that might allow entry of bugs. It was observed that light from the outside was visible through a crack that had no caulking under Resident # 6's heating and AC unit which was installed in the wall by his bed. There was a coin shaped hole in his bathroom door also.
On 1/23/24 at 11:20 AM the Maintenance Director was interviewed and reported the following. Since starting in September 2023 he had tried to identify and repair things. Staff were also to leave him a message or note so that he would know about things they identified. He had not had time yet to check underneath all the wall heating and cooling units to see if there were cracks in the seals.

On 1/24/24 at 9:05 AM the small hole in Resident # 6's bathroom door remained as it appeared on 1/22/24 at 10:10 AM
During an interview on 1/25/24 at 2:35 PM with the Administrator, who began employment on 1/11/24, the Administrator reported the following. He had just begun recently as Administrator, and

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F 584	Continued From page 5 he also was trying to identify issues and resolve them. He was also trying to look into environmental issues. He had already obtained floor samples and was starting to investigate flooring options for the facility.	F 584		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.	F 660		2/22/24

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F 660	Continued From page 6 (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the	F 660		

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F 660	Continued From page 7 discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, staff, physician assistant, independent apartment manager, staff from the Program of All-Inclusive Care for the Elderly (PACE), and contracted van driver for the PACE program, the facility failed to implement an effective discharge planning process that ensured care was coordinated with the resident's primary physician through PACE. On the day of discharge Resident #1 had a change in condition and the PACE physician was not made aware of the change prior to discharge. The PACE program is a community program that helps provide and coordinate medical care and basic care services for older adults. This was for one (Resident # 1) of three residents reviewed for discharge planning. The findings included: The hospital discharge summary dated 12/28/23 indicated Resident # 1 had been hospitalized from 12/19/23 to 12/28/23 and treated for RSV (Respiratory Syncytial Virus) bronchitis. Resident # 1 was admitted to the facility on 12/28/23 with diagnoses which included chronic obstructive pulmonary disease (COPD), hypertension, anxiety, coronary artery disease, and a history of coronary artery bypass surgery. She was discharged on 1/11/24. Upon admission, Resident # 1 was listed as her own responsible party in the medical record. Resident # 1's family member was listed as an emergency contact.	F 660	F660 – Discharge Planning Process Resident #1 no longer resides at the facility. A quality review was completed by the Director of Nursing of current residents receiving PACE services to ensure discharge plan communicated and nurse contacting PACE provider with any change of condition on 2-2-24. An ADHOC Quality Assurance Performance Improvement Committee will be held 1-31-24 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing educated current nurses on contacting PACE provider of any change of condition in resident and communication and coordination with PACE providers of discharge plan by 2-21-23. Nurses not re-educated will not be allowed to work their next scheduled shift prior to being re-educated.	

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Resident # 1's 1/4/24 admission Minimum Data Set Assessment coded Resident # 1 with moderate cognitive impairment. She was assessed to need partial to moderate assistance with her bathing and toileting. According to the assessment, her discharge goal was to go home to a community setting.

Resident # 1's care plan, dated 1/3/24, did not note specific discharge goals. It did note that the resident contracted COVID on 1/2/24. Staff were directed on the care plan to notify the physician for any worsening of her condition.

The facility's Social Worker was interviewed on 1/22/24 at 1:25 PM and reported Resident # 1 was a resident who received PACE services at home, and PACE had managed her care and discharge plan while she was the facility.

During an interview with Resident # 1's family member on 1/22/24 at 12:07 PM by phone the family member reported prior to Resident # 1 becoming sick with RSV, being hospitalized, and residing at the facility, she had resided in an apartment by herself. Through the PACE program, someone came to her apartment one-time a week to help with basic care before she got sick. They also provided transportation for her to go to a Senior Center.

Review of Resident # 1's facility physician's cumulative orders revealed the resident had an order, initiated on 12/29/23, for her oxygen levels to be checked every shift. The order also directed if her level was below 92% she was to have oxygen at 2 liters. A review of Resident # 1's oxygen levels from the date of 1/1/24 through

The Director of Nursing will conduct random Quality reviews of residents with PACE to ensure discharge plan communicated and nurse contacting PACE provider with any change of condition 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

5. The contact number for the PACE provider has been placed in all PACE residents' medical records in Point Click Care/PCC. In addition, the PACE contact information has been placed at ALL nurses' stations: (919) 425-2978 – Provider (919) 425-300 On Call (919) 425-3003 Fax.

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F 660	Continued From page 9 1/10/24 revealed they fluctuated in the range of 90 % to 99 %. Resident # 1 also had an order she could have a Ventolin inhaler 2 puffs as needed for wheezing. Review of physician progress notes revealed there was one entry while Resident # 1 resided at the facility. This was on 1/7/24. The physician noted Resident # 1 had COVID without any fever, chills, or body aches. She was stable and doing well. During an interview with the facility's DON (Director of Nursing), the DON reported the following. The physician who saw Resident # 1 on 1/7/24 was not part of the PACE program. The physician was a contracted physician who saw any facility resident with an urgent need on weekends. These physicians had also been asked to see residents with COVID while in the facility on the weekends, and the date of 1/7/24 had corresponded to a weekend when Resident # 1 had COVID. According to the record, Resident # 1 received physical therapy from 12/29/23 to 1/9/24 and occupational therapy from 12/29/23 to 1/10/24. According to therapy records, the resident had progressed from needing moderate assistance with bathing to set up/clean up for the bathing task. The therapist noted Resident # 1's level of function prior to hospitalization was that she could walk distances within her community using a rollator walker and moderate assistance. On 12/29/23, the day after facility admission, she was assessed to be able to walk 150 feet with her rollator walker and with contact guard assistance (the therapist had their hands on the resident but was not providing physical assistance for her to	F 660		

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walk). Upon therapy discharge, she was assessed to be walking with her rollator walker. The ambulation distance she had achieved was not attempted due to environmental limitations (isolation for COVID).

On 1/11/24 at 1:05 AM the night shift nurse, Nurse # 3, documented Resident # 1's vital signs to be 97.6 temperature, 68 pulse, 18 respirations, and 126/69 blood pressure. Nurse #3 further documented the resident had no shortness of breath and her lung sounds were clear. Nurse # 3 further noted the resident's oxygen was not in use at the time of 1:05 AM.

Resident # 1's MAR (medication administration record) noted on 1/11/24 during the "night" at no specific time that the resident's oxygen saturation was 91%.

Nurse # 3 was interviewed on 1/24/24 at 6:40 AM via phone and reported the following. During the night shift, which began on 1/10/24 and extended to 7:00 AM on 1/11/24, Resident # 1 had been fine. Her oxygen saturation did go down to 91 % at one point. She (Resident # 1) was a "busy" person within the room. She was up and down. Her oxygen saturation would fluctuate. She was placed on her oxygen when it dropped to 91%, and her level came up. She was talking about going home and was having no problems.

On 1/11/24 a physician, who worked with the facility Medical Director's office, signed Resident # 1's discharge orders.

The facility's Social Worker was interviewed on 1/22/24 at 1:25 PM and again on 1/24/24 at 12:50 PM and 1:16 PM and reported the following.

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F 660	Continued From page 11 Resident # 1's PACE contract (an agreement between the facility and PACE for Resident # 1 to receive reimbursement services at the facility) ended on 1/11/24 and PACE had determined she should be sent home. PACE had been aware she had COVID during her facility stay. The facility had just recently started taking PACE residents. The only contact number PACE had given the facility was a PACE Case Manager. The PACE Case Manager, who was a social worker, communicated by email with the facility Social Worker. The PACE Case Manager came to see the resident also. The facility was not provided with a number for the PACE physician provider. On the day of discharge, one of the physicians who worked with the Medical Director was in the facility, and she had asked that physician to sign Resident # 1's discharge order, but he did not see her. During the interview with Resident # 1's family member by phone on 1/22/24 at 12:07 PM the family member stated the PACE's social worker (case manager) had been the one who had coordinated her discharge from the facility. According to the family member, she (the family member) had been concerned that Resident # 1 was going home to be by herself on 1/11/24. The family member felt Resident # 1 had been more confused in the days prior to her facility discharge. Review of discharge papers revealed on 1/11/24 the facility Social Worker and the resident signed a discharge health checklist. The form noted Resident # 1 understood her medical condition and the symptoms she should call her physician regarding. Resident # 1 also checked an acknowledgement that she knew her home health	F 660		

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company's number and her physician's number.

On 1/11/24 at 1:27 PM, Nurse # 4 documented Resident # 1 was placed on oxygen at 2 Liters. On 1/11/24 at 1:44 PM, Nurse # 4 documented Resident # 1 "was discharged to home. Transported by driver from PACE program. Resident became SOB [short of breath] when walking with walker to the van. O2 [oxygen] sats [saturation] were at 88 %, resident was given rescue inhaler, and placed on O2 for transport, resident stated she has O2 tank at home. PACE program instructed driver to take resident home."

Nurse # 4 was interviewed on 1/22/24 at 1:55 PM and reported the following. Resident # 1 had been fine on 1/11/24 prior to her discharge. PACE had sent a driver to take her home. While Resident # 1 was walking to the van from her room, she became short of breath. Resident # 1 sat down in her rollator walker's seat in the facility's lobby. Nurse # 4 instructed the Van Driver not to put the resident in the van. She went to talk to Nurse Unit Manager # 1, who called the Medical Director's on call Physician's Assistant. While this was being done, the Van Driver put Resident # 1 in the van although instructed not to do so. The PA talked to Nurse Unit Manager # 1 and ordered that Resident # 1 be sent home with oxygen. Resident # 1 kept saying she wanted to go home and that she was okay. The Van Driver said he had called PACE. The resident was given her inhaler and placed on oxygen. Her oxygen level went up after this was done. She was unable to recall what the oxygen level went up to. Resident # 1 was determined to go home.

Nurse Unit Manager # 1 was interviewed on 1/23/24 at 12:45 PM and reported the following.

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The resident had been fine prior to discharge. The only time she had been short of breath was when she started walking to the van. The Van Driver was rushing the staff and telling them he was late. He put Resident # 1 in the van. She seemed to be struggling to breathe and Resident # 1 refused to get out of the van and come back in the facility for an assessment to be done. She was determined to go home. Nurse Unit Manger # 1 called the Medical Director's on call PA because it was an emergency situation, and obtained an order to send her home with oxygen. She told Resident # 1 to let her family know she was having a harder time breathing and that she needed to be checked.

The Van Driver, who had been hired by the PACE program to take Resident # 1 home, was interviewed by phone on 1/24/24 at 9:10 AM and reported the following. When he arrived to pick up Resident # 1 she was having a "little trouble breathing." The nurses gave her some oxygen and an inhaler. She seemed to breathe better. She "didn't do any walking" to get to the van. He pushed her on the rollator walker while she sat in the seat. He put her in the van and the nurses were there. He kept a constant conversation going with Resident # 1 as he drove her to her apartment, and she seemed fine. Once she got to the apartment, she did not have her key. The Apartment Manager came to help with that. Once at the apartment, another apartment resident went and got her a wheelchair. Once Resident # 1 was in her apartment, he called PACE and let them know she was inside.

The Apartment Manager was interviewed by phone on 1/23/24 at 10:21 AM and reported the following. When Resident # 1 arrived, she was

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summoned because the resident did not have a key. She walked to the van and found Resident # 1 slouched in the van seat. She asked her if she was okay and the resident responded, "no." Resident # 1 was not able to complete sentences, and her chin kept dropping to her chest. The Van Driver practically "carried" her into the lobby area. Another resident obtained a wheelchair for her. They then got her from the lobby to her apartment. The Apartment Manager called Resident # 1's family member, who came in approximately 20 minutes later and called PACE. PACE sent out an employee who checked Resident # 1 and then called EMS (Emergency Medical Services.) EMS then transported Resident # 1 to the hospital.

Review of Resident # 1's EMS records, dated 1/11/24, revealed the following information. EMS was called on 1/11/24 at 4:00 PM and arrived at 4:06 PM. They found Resident # 1 alert and oriented to person, place, time and situation. She was seated upright on her living room couch wearing her home oxygen and was in no obvious respiratory distress. The resident reported to EMS that she had more shortness of breath that day with movement. She had wheezing upon auscultation (listening with a stethoscope). She was transferred to the hospital for evaluation.

Review of Resident # 1's hospital records revealed she was found in the ED (Emergency Department) on 1/11/24 to have progressive dyspnea (shortness of breath) and elevated lactic acid levels. She was admitted for further care. On 1/22/24 she was discharged from the hospital with her primary discharge diagnosis listed as "lactic acidosis." (a build- up of lactic acid in the bloodstream which at times is caused by low

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oxygen levels).

On 1/23/24 at 3:41 PM the Director of the local PACE program was interviewed by phone and reported the following. At discharge, it had been set up for Resident # 1 to have a home health aide check on Resident # 1 on the afternoon of 1/11/24 at no specific time. A nurse and therapist were to check on her the day following discharge from the facility. PACE had not been alerted that Resident # 1's oxygen saturation had lowered to 88 % right at discharge. If they had been told this, then they would have told the facility to keep her or have her sent to the hospital. They were not aware of any problems on 1/11/24 until Resident # 1's family member called them after she was already in her apartment. There was a main office that the facility should have called.

On 1/24/24 at 10:20 AM Nurse # 4 was interviewed again and reported the nurses did not have a number to call the PACE physician. The Social Worker had only provided them with the PACE Case Manager's number.

On 1/24/24 at 10:25 AM, Nurse Unit Manager # 1 was interviewed and reported she called the Medical Director's PA on 1/11/24 because it was an emergency, and they did not have the number for a physician at PACE to update their physician provider and request further instructions regarding what to do about Resident #1's discharge.

On 1/24/24 at 10:00 AM PA # 1 was interviewed and reported PACE was a new program for the facility. The PA further reported the facility's Physician Assistants worked for the Medical Director. She had not been the PA who had been

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contacted on 1/11/24 but given that Resident # 1 had a diagnosis of chronic obstructive pulmonary disease, it would not be indicated to keep her oxygen level too high. (Residents with COPD can have a build -up of carbon dioxide from too much oxygen because of their impaired respiratory system, and therefore they tend to have a lower oxygen level than someone without COPD.) Theoretically, the staff were to call and talk to the PACE physician about PACE residents. The PACE physicians were the ones to make decisions about their care and be updated. The PAs in the facility's Medical Director's office covered for the facility when there was an emergency.

Attempts were made to contact the PACE Case Manager on 1/22/24 at 1:27 PM and 1/23/24 at 1:30 PM. A voice mail was left asking for a return call, and none was received.

During the interview with the PACE Director On 1/23/24 at 3:41 PM the Director reported the PACE Case Manager was on vacation.

On 1/22/24 at 1:57 PM the Director of Nursing (DON) reported the staff had not reported a problem to her about Resident # 1's discharge. She had just begun as the DON on 1/11/24 (the day Resident # 1 was discharged.)

On 1/24/24 at 11:50 AM, the DON reported she could not find any indication in the record that Resident # 1's PACE physician had been consulted on 1/11/24 regarding the discharge for that date.

On 1/24/24 at 3:19 PM an interview with the Administrator, who also began on 1/11/24 (the

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F 660	Continued From page 17 date of Resident # 1's discharge), revealed the PACE program was also new to him and he had not been part of the set up with the program.	F 660		
F 695 SS=D	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 staff, and contracted respiratory therapist interviews the facility failed to ensure 1) individualized care for Resident # 10's tracheostomy was clarified regarding routine frequency of care and type of inner cannula he needed 2) supplies were available to exchange his disposable inner cannula and 3) clarification regarding when the resident's external cannula exchange should be completed. This was for one of two sampled residents with a tracheostomy (Resident # 10). The findings included: Resident # 10's specialty hospital discharge summary dated 12/8/23 indicated Resident # 10 had made slow progress. The discharge summary noted Resident # 10 had a tracheostomy and was tolerating a PMV (Passy-Muir Speaking Valve. A PMV allows a tracheostomy resident to speak). It also directed that tracheostomy capping (when the airflow is	F 695	F695 – Respiratory/Tracheostomy Care and Suctioning Resident #10 discharged on 1-26-24. A quality review was completed by the Director of Nursing of current residents with Tracheostomies to ensure Tracheostomy care orders obtained to include type and care of cannula on 2-13-24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 1-31-24 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing educated current nurses on obtaining orders for Tracheostomy care related to type and care of cannula by 2-21-24. Nurses not	2/22/24

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blocked from flowing through the tracheostomy cannula and is at times done as a person progresses to possibly no longer needing the tracheostomy) was no longer needed and there were no plans for decannulation (removing the tracheostomy).

A tracheostomy is a surgically made opening into the trachea to facilitate breathing. Some individuals have both an external and an internal cannula (tube) inserted into the surgical opening. The inner cannula fits within the external cannula. Some inner cannulas are disposable, and others are non-disposable and require cleaning. The outer tracheostomy cannula has an outward piece which fits against a resident's neck and is secured with tracheostomy ties that are tied around an individual's neck.

Record review revealed Resident # 10 was admitted to the facility on 12/8/23 with diagnoses including stroke, respiratory failure, anemia, hypertension, hyperosmolarity and/or hypernatremia, seizure disorder, chronic kidney disease, dysphagia, congestive heart failure, and diabetes.

Resident # 10's nursing admission assessment, dated 12/8/23 and completed by Nurse Unit Manger # 2, included documentation that the resident had a tracheostomy. The assessment included an area where nurses were to include the type and size of tracheostomy when they completed the assessment. The cannula size was written as "6" and there was no further information on the assessment regarding the tracheostomy type. There was also an area on the assessment where nurses could enter "other" information. There was no documentation

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re-educated will not be allowed to work their next scheduled shift prior to being re-educated.

The Director of Nursing a will conduct random Quality reviews of residents with tracheostomies to ensure orders obtained for trach care to include type and care of cannula 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.
The Director of Nursing and The Central Supply Department has established a PAR Level for all needed Respiratory / Tracheostomy Care and Suctioning supplies to ensure levels don't fall below what is needed. Orders are placed weekly and as needed to maintain PAR level.

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regarding the PMV noted in the resident's hospital discharge summary.

On Resident # 10's admission date of 12/8/23 there were no orders obtained for the care of the tracheostomy.

Nurse Unit Manager # 2 was interviewed on 1/25/24 at 10:25 AM and reported the following. When a resident with a tracheostomy arrived, there were a "batch" of orders in the electronic system which needed to be initiated. The batch of orders addressed such things as the care of the tracheostomy and the size and type of cannula the resident had. They had respiratory therapists who came twice per week to the facility to help with tracheostomy residents. She recalled Resident # 10's tracheostomy was capped when he first came to the facility. She did not know why the specific orders had not been initiated for his individualized needs upon admission on 12/8/23.

On 12/9/23 at 2:35 PM, Nurse # 1 documented Resident # 10 had a tracheostomy that was present and was capped.

Review of Resident # 10's December 2023 orders revealed an order dated 12/12/23 for tracheostomy care as needed. This was the first order which addressed tracheostomy care for the resident.

The "as needed tracheostomy care" order did not appear on Resident # 10's 2023 December MAR/TAR (Medication Administration Record and Treatment Administration Record). There were no orders or directions regarding if or when routine tracheostomy care should be done or whether the resident had a disposable or non- disposable

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inner cannula.

There were physician orders, dated 12/11/23, to suction the resident as needed. Also, on 12/12/23 there were orders to assess the skin around the stoma site and under the tracheostomy ties during tracheostomy care, and to change the ties as needed or when soiled.

Resident # 10's 12/14/23 Minimum Data Set (MDS) admission assessment included the following information. The resident was moderately cognitively impaired and dependent on staff for activities of daily living. He was assessed to need suctioning. Tracheostomy was not checked on his assessment.

Resident # 10's care plan, dated 12/14/23, noted the resident had a tracheostomy. Staff were directed on the care plan to ensure that the tracheostomy ties were secured at all times and to suction the resident as necessary. There were no directions on the care plan regarding whether the resident had a non-disposable inner cannula or disposable cannula and the frequency of routine tracheostomy care that was to be done.

On 1/26/24 at 4:20 PM during an interview with the Director of Nursing (DON), the DON reported the facility had respiratory therapy services available through a contracted provider. This provider would send a respiratory therapist to the facility to assist with tracheostomy residents. The contract had been in place since June 2012.

Review of a list Resident # 10's cumulative physician orders to address tracheostomy care, which was printed from the facility's electronic system on 1/26/24, did not reveal an order for

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respiratory therapy.

According to the record, Resident # 10 was first seen by a Respiratory Therapist (RT) on 1/10/24. RT # 1 documented Resident # 10 was on room air, received sterile tracheostomy care and was stable.

On 1/10/24 a Physician order was written for the resident to have tracheostomy care as needed two times a day for infection control. The order was scheduled on Resident # 10's TAR for 9 AM and 5 PM and initialed as completed from 1/10/24 to 1/13/24.

On 1/12/24 RT # 1 noted she saw the resident again. RT # 1 documented Resident # 10 was on room air with an oxygen saturation of 93%. His breathing was unlabored. He received tracheostomy care using the sterile method.

On 1/12/24 at 1:08 PM Resident # 10's Physician Assistant (PA) noted she was reviewing Resident # 10 for "follow up on labs." The PA further noted the following information. She spoke to the resident's family who were concerned because they felt there had been an overall decline in the resident. The resident's mentation appeared to wax and wane. He was alert and in no distress at the time the PA was seeing him. His breathing was unlabored. He had a tracheostomy with a PMV (Passy-Muir Speaking Valve (PMV) in place.

On 1/12/24 Resident # 10's temperature registered 98.1.

Review of Resident #10's January 2024 MAR and TAR revealed as of 1/12/24 there was no documentation Resident # 10's outer

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tracheostomy cannula had been changed.

On 1/13/24 at 3:35 PM Nurse # 1 documented the following. Resident # 10 was observed with abdominal breathing. His respiration rate was 24 per minute and labored. She administered a breathing treatment and suctioned a small amount of thick yellow mucous with no relief. The inner cannula was changed. His temperature was 99.6. "911" was called and Resident # 10 was transferred to the hospital for care.

Nurse # 1 was interviewed on 1/25/24 at 8:40 AM and again at 3:15 PM. Nurse # 1 reported the following. Resident # 10 was coughing every day when he first arrived in December 2023. Initially he could bring up his sputum but at some point, they had to start suctioning him. The sputum was not discolored prior to 1/13/24. It was clear. On that date (1/13/24) he had increased secretions, yellow sputum, and some trouble breathing. She gave him a nebulizer treatment which had been ordered and he seemed to improve some. In 20 minutes, he started to have trouble again, and so she had him sent to the hospital. Nurse # 1 was also interviewed about the frequency of tracheostomy care and how they knew whether to clean or dispose of the inner cannula. Nurse # 1 reported they did tracheostomy care every shift. They had sterile kits to do so. The inner cannula was different when he first came to the facility in December 2023 compared to after he was hospitalized on 1/13/24. She recalled cleaning the cannula during tracheostomy care but did not recall throwing one away. She was not sure. She also did not know when the resident went from being capped to being suctioned.

Resident # 10 was hospitalized from 1/13/24 to

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1/17/24. According to the 1/17/24 hospital discharge summary the resident had presented to the hospital with increased secretions and shortness of breath. He was treated for "presumed tracheitis" and hypernatremia (high sodium level). According to the discharge summary, he was to continue to have tracheostomy care at the facility following his discharge on 1/17/24. The 1/17/24 hospital discharge summary noted Resident # 10 would need continuous tracheostomy care. There were no specific instructions to define "continuous" on the discharge summary.

On 1/17/24 Resident # 10 was readmitted to the facility. Orders were initiated on 1/17/24 to suction every shift and as needed, tracheostomy care as needed, to assess the tracheostomy stoma site and under the ties during tracheostomy care, and to change the tracheostomy ties when soiled and as needed. On 1/17/24 the first order appeared for the type of cannula Resident # 10 was to have. It was noted to be a Size 6 "Shelley" cannula.

On 1/18/24 RT # 2 saw Resident # 10 and documented she had completed tracheotomy care and the inner cannula and dressing were changed. The stoma and flange (the outside end of the outer cannula that sits against the resident's neck) was cleaned and equipment was changed and dated. Supplies were restocked and emergency equipment was at the bedside. The resident's respirations were not labored, and he had tolerated the procedure well.

On 1/25/24 at 3:15 PM Nurse # 1 and the Director of Nursing were accompanied to Resident # 10's room. He was observed to have humidity via way

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of trach collar and was breathing without any signs of distress or labored breathing. He was not coughing or in need of suctioning. There were supplies of sterile tracheostomy care kits in the room and extra inner cannulas which according to the DON were not clearly marked as disposable versus non-disposable.

Interview with the Director of Nursing (DON) on 1/25/24 at 3:30 PM revealed respiratory therapists came to the facility two times a week to help with tracheostomy residents. The DON, who had just recently begun as the DON on 1/11/24, stated she would follow up with the respiratory therapy provider to see what they knew regarding Resident # 10's care. She was aware that since Resident # 10 had been readmitted on 1/17/24 that she had been told that he had a non-disposable inner cannula but was not familiar with what he had prior to his 1/13/24 hospitalization.

Nurse # 2, who routinely cared for Resident # 10 on the night shift, was interviewed on 1/26/24 at 7:00 AM and reported the following. When Resident # 10 first was admitted in December 2023 his tracheostomy was capped. He had a disposable inner cannula, but due to supplies and the issue with it sometimes not being dated, they just cleaned the cannula and reinserted it. At other times they disposed of the inner cannula. They did tracheostomy care every shift and passed along the information in report so that the nurses would know what was done for him. When he returned from the hospital on 1/17/24 he had been changed to a non-disposable inner cannula. She was not aware if the external tracheostomy cannula had ever been changed.

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RT # 1 was interviewed on 1/25/24 at 2:50 PM and reported the following. Prior to going to the hospital on 1/13/24 Resident # 1 had a disposable inner cannula which should have been changed out daily. She did not start caring for him in December 2023. She recalled it was around 1/9/24 before she saw him. She had not been asked to see Resident # 10 or have orders to do so prior to the date around 1/9/24. She typically found out if she needed to see a resident because she would be asked by the Unit Manager or DON to start seeing a resident. She did not recall who asked her to see Resident # 10 for the first time. When she first starting caring for Resident # 10 in January, she did not recall any problems with his tracheotomy. RT # 1 reported she helps make sure supplies were stocked for residents with tracheostomy residents.

During the phone interview on 1/25/24 at 2:50 PM, RT # 1 placed her RT supervisor on the phone who reported the following during the interview. Per a standard of care, tracheostomy residents should have tracheostomy care at a minimum of once per day and as needed. If the inner cannula is disposable, then it is to be thrown away and another one placed during daily tracheostomy care. The outer cannula is to be changed monthly. At times, even with appropriate care, tracheostomy residents can develop infections. Things that contribute to infections are friction, extra granulation tissue around the stoma site, and increased secretions. If a resident comes in with a tracheostomy capped, then it should be documented why the resident was uncapped and the circumstances occurring to necessitate the resident not being capped.

On 1/26/24 at 2:23 PM the facility DON was

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F 695	Continued From page 26 interviewed again and reported the following. She had called and talked with the respiratory therapy supervisor to clarify more about their services and learned the following. A referral from the facility can be made to respiratory therapy via way of a portal or it can be called in. Also, when one of the respiratory therapists are onsite in the facility, the staff can let them know that they have a new tracheostomy resident and request for the resident to be seen. The respiratory therapy records showed that Resident # 10 was seen for the first time on 1/10/24. During the initial visit the respiratory therapist should make an initial assessment of the type of tracheostomy a resident has, what his needs are, what settings he needs, and what services he needs from respiratory therapy. They then make the recommendations, and the orders can be obtained from the physician/physician assistant. The respiratory therapist had looked through their records and found this initial assessment had not been done by their respiratory therapist for Resident # 10. The DON had clarified that there were only three times the resident was documented as seen by a RT. The RT supervisor reported examples of things that needed to be clarified for tracheostomy residents were the size and type of cannula a resident has, if it is disposable or non-disposable, based on the resident's needs and facility policy whether the resident needs suctioning and how often, tracheostomy care to be done, and humidity settings. Given that the DON had just recently started, the DON was not familiar with what had transpired with Resident # 10 which resulted in him not having clarification of orders or being evaluated by respiratory therapy. She did not know what had transpired to result in him not having supplies when he used to have the	F 695		

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F 695	Continued From page 27 disposable cannula. As a new DON to the facility, she was still identifying what processes had been being followed and evaluating what needed to be changed about them. Physician Assistant # 1 was interviewed on 1/25/24 at 12:15 PM and reported the following. The PAs relied on respiratory therapy to recommend the treatment and care of a resident's tracheostomy. She felt the nurses had been caring for Resident # 10's tracheostomy although the orders had not always been clearly defined.	F 695		
F 755 SS=E	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 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.	F 755		2/22/24

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F 755	Continued From page 28 §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, resident interview, and staff interviews the facility failed to obtain medications from the pharmacy for administration. This was for two (Residents # 1 and # 5) of two residents whose medications were reviewed. The findings included: 1. Resident # 1 resided at the facility from 12/28/23 to 1/11/24. The resident had diagnoses which included chronic obstructive pulmonary disease, hypertension, anxiety, coronary artery disease, and a history of coronary artery bypass surgery. Prior to residing at the facility, Resident # 1 had been hospitalized from 12/19/23 to 12/28/23 and treated for RSV (Respiratory Syncytial Virus) bronchitis. Resident # 1's care plan, dated 1/3/24, noted Resident # 1 contracted COVID on 1/2/24. On 1/5/24 Resident # 1 was ordered to receive Molnupiravir 200 mg (milligrams) four capsules two times per day. (Molnupiravir is a an antiviral medication used to treat COVID.) Review of Resident # 1's January 2024 MAR (Medication Administration Record) revealed the medication was scheduled to be given at 9 AM and 5 PM.	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records 1. Residents #1 no longer resides at the facility. Resident #5 discharged from facility on 2-6-24. 2. The last 30 days of admissions were reviewed to ensure medications present and being administered as ordered on 1-31-24 by the Director of Nursing and Unit Managers. Residents currently receiving antibiotics/antivirals were audited to ensure medications given per MD orders and documented on medication administration record per time frame on 2-15-24 by the Director of Nursing. 3. The Director of Nursing will re-educate nurses on pharmacy procedures for ordering of medications to include for new admissions, ensuring prescriptions for controlled medications received and use of Omnicell by 2-21-24. At any time, resident presents with controlled medication without a prescription,	

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On 1/5/24 at 5 PM, Nurse # 6 documented the facility was awaiting delivery of the medication. The medication was not documented as given.

On 1/6/24 at 9 AM, Nurse # 7 documented the facility was awaiting delivery of the medication. The medication was not documented as given.

On 1/22/24 at 2:40 PM, the Director of Nursing (DON), was interviewed and reported the following. She had become DON on 1/11/24 and was beginning to identify and address medication issues. According to records she had reviewed, the pharmacy had delivered the Molnupiravir on 1/5/24 during their last delivery to the facility. It would have arrived between 9 PM and 11 PM that night. Nurse # 7 should have then started the medication the next morning. The Molnupiravir medication did not come in a bubble pack like many of the other medications. It came in a box. The DON speculated that the nurse may have looked for a bubble pack and not realized the medication was packaged differently.

Nurse # 7 was interviewed on 1/23/24 at 2:25 PM and stated she did not know why it was not given. She could only go by what she had written in the note, which was awaiting pharmacy.

Review of physician progress notes revealed Resident # 1 was evaluated by a physician on 1/7/24 who documented she had COVID without any fever, chills, or body aches. She was stable and doing well.

2. Resident # 5 was admitted to the facility on 1/19/24. Prior to her facility residency, Resident # 5 had been hospitalized and had surgery for a Stage 4 pressure sore. She also had a diagnosis

F 755

Physician must be called, and prescription obtained. Stat
delivery and back up pharmacy must be utilized if outside of normal pharmacy hours. The
Director of Nursing will re-educate nurses and medication aides on all medications should be
given as ordered per physician's order to include antibiotics/antivirals to ensure medications
given for entirety of ordered time frame. If ordered medication not present Omnicell should be
utilized, and medication removed from Omincell. In the event ordered medication not present in
Omnicell back up pharmacy should be contacted to send medication. At any time ordered
medication not given per order, MD must be contacted for further orders. Ordered Medication
should not be documented as medication unavailable: Omnicell, back up pharmacy, and or new
order is the process for medication not present. DON should be contacted with concerns.
Education will be completed by 2-21-24.
4. The Director of Nurses/ Unit Manager will complete quality monitoring on 10 residents'
medication administration records weekly for 12 weeks then monthly times 3 months to ensure
medication given per order to include controlled medications, and medication given per time

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of a major depressive disorder.

Review of admission orders revealed an order, dated 1/19/24, for Oxycodone-Acetaminophen 5-325 mg (milligrams) every four hours as needed for pain.

Review of admission orders revealed an order, dated 1/19/24, for Acetaminophen 500 mg every eight hours as needed for pain and/or fever.

Resident # 5 also had an admission order, dated 1/19/24, for Lorazepam 0.5 mg two times per day for anxiety for 14 days. Following the initial 14 days, the Lorazepam was to be tapered off by giving 0.5 mg daily times seven days.

Review of Resident # 5's January 2024 Medication Administration Record (MAR) revealed Resident # 5 was not documented to receive any PRN doses of Acetaminophen or Oxycodone-Acetaminophen between the dates of 1/19/24 through 1/21/24.

Review of Resident # 5's January 2024 Medication Administration Record (MAR) revealed the Lorazepam was scheduled to be administered at 9 AM and 5 PM. The MAR also included the following.

On 1/19/24 at 5 PM Nurse # 6 documented "9 beside the Lorazepam." There was no check mark the medication was given.
On 1/20/24 at 9 AM, Nurse # 7 documented "9 beside the Lorazepam." There was no check mark the medication was given.
On 1/20/24 at 5 PM, Nurse # 6 documented "9 beside the Lorazepam." There was no check mark the medication was given.

F 755

frame. If medications not given MD was called with further order. Opportunities will be
corrected by the Director of Nursing/Unit Manager as identified during these reviews. The
results of these quality reviews will be submitted to the Quality Assurance and Performance
Improvement Committee (QAPI) by the Director of Nursing for review by the Interdisciplinary
members each month. The QAPI committee will evaluate the effectiveness and amend as
needed.

F 755 Continued From page 31 F 755

On 1/21/24 at 9 AM, Nurse # 8 documented "9 beside the Lorazepam." There was no check mark the medication was given.
On 1/21/24 at 5 PM, Nurse # 6 documented "9 beside the Lorazepam." There was no check mark the medication was given.

The first time the Lorazepam was documented as given was on 1/22/24 at 9 AM.

Resident # 5 was interviewed on 1/22/24 at 8:50 AM and reported she just arrived on 1/19/24. They had not had her oxycodone available. They had given her Tylenol (Acetaminophen) over the week-end of 1/19/24 to 1/22/24, and it took a while to work. She was concerned about the availability of her medications.

Nurse # 6 was interviewed on 1/23/24 at 3:15 PM and reported the following. When Resident # 5 arrived on 1/19/24, some of Resident # 5's prescriptions had not been sent with the discharge orders. The pharmacy needed the prescriptions. On Friday (1/19/24), she had not done the admission paperwork to realize the prescriptions were missing. On Saturday, 1/20/24, she realized the prescriptions were needed but she was not certain an on-call physician would give them. She therefore put the issue down for the physician/PA (physician assistant) to address on Monday 1/22/24 when they routinely came in. There were some back up medications in the facility, but most of the time some of them were out of date. She did not try to acquire the Lorazepam. She was not aware Resident # 6 had an order for Oxycodone-Acetaminophen and that it had not been delivered from the pharmacy and needed to be addressed. The resident was crying and

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hurting on the 1/20/24 evening shift and she gave her Acetaminophen. It seemed to work for her. She got quiet and rested after the administration of the Acetaminophen. She had not documented she had given her the Acetaminophen or its effectiveness.

Interview with the MDS Nurse on 1/24/24 at 8:42 AM revealed on 1/19/24 she had printed off Resident # 5's discharge summary from the electronic system and had the Physician's Assistant sign it, but she had not been aware there was a problem with needed prescriptions.

Nurse # 7 was interviewed on 1/23/24 at 2:25 PM and reported the following. She did not routinely work at the facility and did not recall Resident # 5 or the specifics of her care and medications.

Nurse # 8 was interviewed on 1/23/24 at 2:35 PM and reported the following. She had just been employed at the facility since November 2023. She did not have access to the medications in back up. There was no supervisor to get Lorazepam for her when she worked , and at times when she asked other nurses to obtain medications, they were expired. The facility did not keep Oxycodone in back up, but Resident # 5 did not complain to her of pain during her shift.

The DON (Director of Nursing) was interviewed on 1/22/24 at 2:40 PM and 1/23/24 at 11 AM and reported the following. She had become the DON on 1/11/24. She was aware there were some problems with medications being checked in the back up medication supply and reordered timely. She had submitted the paperwork to oversee the medications in back up to resolve issues with availability and expiration. Resident # 5 had

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F 755	Continued From page 33 arrived without some of her prescriptions on 1/19/24, and the nurses should have called the on- call physician and obtained the prescriptions so Resident # 5's medications would be available.	F 755		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility laboratory employee interview the facility failed to ensure a urine specimen was received by the facility's lab in a timeframe which the lab considered acceptable to run the specimen for results. This was for one (Resident # 10) of one sampled resident whose lab results were reviewed. The findings included: Record review revealed Resident # 10 was admitted to the facility on 12/8/23. Resident # 10's diagnoses in part included stroke, gastrostomy placement, and tracheostomy placement. Review of Resident # 10's lab report results revealed a urine analysis and a urine culture specimen were collected on 1/10/24. There was no order entered in Resident # 10's electronic medical record for the lab to be done.	F 770	F770 – Laboratory Services 1. Resident #10 discharged on 1-26-24. 2. A quality review was completed by the Director of Nursing of last 30 days of current residents with ordered labs to ensure labs obtained and lab received within timeframe to run lab and physician notified on 1-31-24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 1- 31-24 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing educated current nurses on lab process to include placing order for lab, lab pickup and receiving results by 2-21-24. Nurses not re-educated will not be	2/22/24

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The lab report included documentation that the lab received the specimen six days after it was collected. Specifically, the report lab noted the received date was 1/16/24 and that the results were reported on 1/18/24.

The urinalysis results showed the urine was negative for blood and nitrites. The urinalysis showed "many" bacteria. The urine culture result showed greater than 100,000 colonies of Klebsiella Oxtytoca with resistance due to ESBL extended spectrum. (Extended-spectrum beta-lactamases). ESBL are enzymes secreted by some bacteria which make them resistant to some antibiotics.

A CBC (Complete Blood Count), which was collected on the same day (1/10/24) as the urine specimen, showed a result that Resident # 10's White Blood Count was within normal range. This was reported on 1/11/24. (At times an elevated blood count can indicate infection.)

Resident # 10's vital sign assessments showed he was afebrile on 1/10/24 through 1/12/24.

On 1/13/24, Resident # 10 was transferred to the hospital for evaluation secondary to an increased rate of respirations and labored breathing. He remained hospitalized from 1/13/24 through 1/17/24. A urinary tract infection was not listed as one of his discharge diagnoses on the 1/17/24 hospital discharge summary.

PA # 1 was interviewed on 1/25/24 at 12:15 PM and reported the following. She reviewed the hospital notes and reported the hospital indicated Resident # 10 may have had a mild urinary tract infection upon admission. PA # 1 further reported

F 770 (Plan of Correction)

allowed to work their next scheduled shift prior to being re-educated.
4. The Director of Nursing a will conduct random Quality reviews of 5 residents with lab
orders 2 times a week for 8 weeks then weekly for 4 weeks to ensure lab obtained, lab
received within timeframe to run lab and physician notified timely. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI
committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 35	F 770		

if they had received the urinalysis prior to his transfer to the hospital on 1/13/24, the facillity would have further assessed him but not definitely treated him for a urinary tract infection given that his leukocytes (white blood cells) were normal, he had no nitrites in the urine, and he was not running a fever. The PA indicated at times residents can be colonized with bacteria without an active infection.

Nurse Unit Manager # 2 was interviewed on 1/25/24 at 10:25 AM and reported the following. She had gotten a verbal order to obtain Resident #10's urine specimen for urinalysis and culture. The family had been concerned he was acting differently. She did not put the order in the electronic system, but she had collected it on 1/10/24 and placed the specimen in the facility refrigerator for pick up by the facility's lab company. The lab company routinely sent a phlebotomist in during the early AM hours, and the phlebotomist picked up any urine specimens at that time. Therefore, the specimen should have been picked up by them on the morning of 1/11/24. She did not know why the lab report showed it was not received by the lab until 1/16/24.

On 1/25/24 at 1:30 PM an employee from the facility's lab company was interviewed via phone and reported the following. They send a phlebotomist to the facility Monday through Friday and their phlebotomists are trained to check the lab book and refrigerator for any specimens that have been collected by the facility. If they receive a urine specimen that is greater than 72 hours old, then they are supposed to reject the specimen. If the phlebotomist had not seen any requisition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING ______ B. WING ______	C 01/26/2024

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F 770	Continued From page 36 paperwork in the lab book, they may have not known to check the refrigerator. The employee could not say what the problem had been in the delay. Interview with the DON (Director of Nursing) on 1/22/24 at 1:57 PM and on 1/24/24 at 11:50 AM revealed she began as DON on 1/11/24. She did not know why the urine result showed it was not received until 1/16/24. The resident had been sent out to the hospital on 1/13/24 and was hospitalized when the lab showed it was received by them.	F 770		