STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HEALTH & REHAB CENTER	54 RED MULBERRY WAY LILLINGTON, NC 27546

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/6/2024 through 5/10/2024. Additional information was obtained on 5/24/2024 and 5/28/2024. Therefore, the exit date was changed to 5/28/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V3JX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/6/2024 through 5/10/2024. Additional information was obtained on 5/24/2024 and 5/28/2024. Therefore, the exit date was changed to 5/28/2024. The following intakes were investigated NC00200236, NC00204897, NC00207021, NC00209143, NC00209488, NC00212731, NC00214798, NC00215654, NC00216517 and NC00217242. 7 of 24 complaint allegations resulted in deficiency.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F 577		6/14/24

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

Electronically Signed | 06/13/2024

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F 577	Continued From page 1 residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to display survey results in a location accessible to residents during observations of the facility. This failure affected all residents in the facility. The findings included: During a tour of the facility on 5/07/24 at 10:07 AM, the survey results were not located in the building. A Resident Council group meeting was conducted on 5/08/24 at 1:15 PM. During the meeting, the residents indicated the survey results were located on a wall near the nurse's station. Tours of the facility on 5/08/24 at 1:26 PM and 5/10/24 at 8:54 AM revealed the survey inspection results binder were not located in the facility. In an interview on 5/10/24 at 8:54 AM, Nurse #2 stated she was not aware of the location of the	F 577	1. Survey results were located in facility on the left side of the 4 foot reception desk and no signage was posted to designate the location of the survey results. 2. Survey result notebook was relocated on 5/10/24 for a small table in reception area (approximately 2 feet tall) and signs were posted at both nursing stations with the new location of the survey book. 3. Resident were informed of new location of survey result notebook during resident council meeting on 6/11/24. Staff were educated on location of survey result notebook on 6/11/24. 4. Receptionist will verify survey result notebook is present when they arrive to work weekly x 4 weeks. If not able to locate, the receptionist will notify the administrator immediately.	

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F 577	Continued From page 2 survey inspection results. In an interview on 5/10/24 at 8:56 AM, the Social Worker indicated she was not aware of where the survey results were posted and indicated Nurse #2 should know. During an interview and observation conducted with the Administrator on 5/10/24 at 9:11AM, he stated the survey inspection results book was available at the reception desk. An observation of the front reception desk revealed the survey result book was located on the far-left side of the four-foot-high reception desk. A 5 ft. easel and a large leaf plant were observed directly in front of the survey results. There was no signage to designate the location of the survey results. The Administrator indicated he would post a sign and place the survey results on a table within residents' reach.	F 577		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		6/14/24

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F 657	Continued From page 3 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, residents and staff interviews, the facility failed to allow a resident to participate in the development of their care plan for 1 of 6 residents reviewed for care plan participation (Resident # 66). The findings were: Resident #66 was admitted to the facility on 10/31/2023 and was discharged from the facility due to a hospitalization on 11/28/2023. Resident #66 was re-admitted to the facility on 12/1/2023. Resident #66's initial care plan dated 11/01/2023 had been updated on the following dates: *12/11/2023 to include a focus for bladder incontinence related to immobility. *2/19/2024 to include a focus for long term placement at the facility due to wound care. *3/13/2024 to include a focus for edema. There was no documentation of a care plan meeting that included the resident's participation in Resident #66's medical record since his readmission on 12/1/2023.	F 657	1. Resident #66 - care plan meeting for this quarter was held on 5/30/24 and resident attended. 2. All current residents were reviewed for care plan meetings on 5/07/24 and have one scheduled for this quarter or recently had a care plan meeting. 3. Regional Clinical Reimbursement Specialist completed education with Minimum Data Set (MDS) nurses. Education completed 5/29/24. 4. Regional Clinical Reimbursement Specialist or designee will perform random audits of care plan meeting schedules x 12 weeks to ensure all residents have care plans in the quarter. Results to be reported in QAPI x 3 months.	

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F 657	Continued From page 4	F 657		

Quarterly Minimum Data Set (MDS) assessments were conducted on 12/20/2023 and 02/20/2024 and both indicated Resident #66 was cognitively intact.

In an interview with Resident #66 on 5/7/2024 at 8:53 a.m., he stated he attended a care plan meeting but had not had a care plan meeting in a long time. He was unable to recall the date of his last care plan meeting. He stated he needed a care plan meeting to discuss management of his Diabetes Mellitus.

In an interview with MDS Nurse #1 on 5/8/2024 at 6:38 a.m., she explained the MDS Nurses were responsible for scheduling and notifying Resident #66 and interdisciplinary team members of a care plan meeting. She stated she could not see where a care plan meeting had been held with Resident #66 since his readmission 12/1/2023. She explained Resident #66 had been in and out of the facility due to hospitalizations and that shuffled her scheduling of Resident #66's care plan meetings. She stated she tried to schedule quarterly care plan meetings close to the time of the quarterly MDS assessment but had not always met that goal. She explained a "Your Path" (a short form used for initial 24 to 48-hour care plan meetings) was conducted for readmissions, and she was unable to locate a "Your Path" form for Resident #66 since 12/1/2023. After reviewing the care plan calendar, she said a care plan meeting had not been scheduled for Resident #66 since readmission.

In an interview with the Director of Nursing on 5/9/2024 at 9:01 a.m., she explained the MDS nurses were responsible for organizing and

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F 657	Continued From page 5 conducting care plan meetings for the residents at least quarterly and when there was a significant change in a resident. She stated Resident #66 should have had a "Your Path" or a care plan meeting since his readmission to the facility. She stated if a care plan meeting was not found since his readmission, it must have been missed due to his hospitalizations. In an interview with the Administrator on 5/10/2024 at 12:25 p.m., he stated care plan meetings needed to be scheduled and conducted for Resident #66 around the time of the quarterly MDS assessments.	F 657		
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 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 record review, resident interview and staff interviews, the facility failed to provide incontinence care to a resident that was incontinent for 1 of 4 residents dependent on staff for activities of daily living (ADL) care (Resident #244). Findings included: Resident #244 was admitted to the facility on 4/18/2024 to the facility with diagnoses including Diabetes Mellitus and hypertension. Resident #244's care plan dated 4/19/2024 included a focus for assisting with activities of	F 677	1. Call light was answered by Director of Nursing (DON) and Unit Manager on date in question and resident was assisted to the restroom. Resident #244 discharged from facility on 6/04/24. 2. Skin sweep performed on all cognitively impaired residents by nurses and interviews completed on cognitively intact residents by nurses. Completion 6/11/24. 3. DON/designee provided education to all staff about answering call lights in a timely manner. Education will be provided to all new hires during orientation. Education completed 6/13/24. 4. DON/designee to perform random call	6/14/24

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F 677	Continued From page 6 daily living and stated Resident #244 required one person to assist with toileting. The admission Minimum Data Set (MDS) assessment dated 4/24/2024 indicated Resident #244 was cognitively intact, had an indwelling urinary catheter, frequently was incontinent of stool and was dependent on nursing staff for toileting. Physician orders dated 4/30/3024 indicated Resident #244's urinary catheter was discontinued. Physical Therapy Aide (PTA #1) recorded on 5/6/2024 in Resident #244's therapy notes she was tearful and was waiting for incontinent care, and Resident #244 requested not to have therapy. In an interview with Resident #244 on 5/6/2024 at 3:49 p.m., she stated she was wearing an adult brief wet with urine and waited two hours that morning of 5/6/2024 to be changed. There was a clock observed hanging on the wall in front of Resident #244's bed. She explained she used the call bell to notify the nursing staff and when someone came into the room, she told them she needed to be changed and was not changed. She stated a staff member turned off the call bell, told her she would be back and exited the room. Resident #244 did not know the name of the staff member. She stated she did not press the call bell again because she thought a staff member was coming back to change her. She explained during the time she was waiting to be changed, therapy staff came to provide her therapy for the day but she couldn't participate because she needed to be changed. Resident #244 said with a	F 677	light audits 3 times a week x 12 weeks and skin assessments for 5 cognitively impaired residents weekly x12 weeks. Results to be reported in QAPI x 3 months by the DON.	

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F 677	Continued From page 7	F 677		

stern voice and serious facial expression that having to wait two hours to change her adult brief and missing her therapy on 5/6/2024 made her feel irritated. Resident #244 did not mention crying or being tearful as a result of the incident.

In an interview with Nurse Aide (NA) #6 (who was assigned to Resident #244 on 5/6/2024) on 5/10/2024 at 1:33 p.m., she stated Resident #244 usually got out of the bed early in the mornings due to receiving therapy in the mornings. She explained Resident #244 would use her call bell to inform the nursing staff when she needed to be changed. She stated she could not recall answering Resident #244's call bell on the morning of 5/6/2024 and was not aware that Resident #244 had to wait to receive incontinent care. She explained if she was in another resident's room providing care, she would not be able to answer the call bell. In a follow-up interview with NA #6 on 5/10/2024 at 2;48 p.m., she stated she could not recall whether or not she changed Resident #244 on the morning of 5/6/2024 and stated there were other nursing staff that could answer Resident #244's call bell and change her.

In a phone interview with PTA #1 on 5/10/2024 at 2:41 p.m., she stated the morning of 5/6/2024 (she was unable to recall exact time) when she went to provide Resident #244 therapy, she was tearful and upset because she was waiting to receive incontinent care and had been waiting a long time. She was unsure how long she had been waiting. She explained Resident #244 had never refused therapy and due to Resident #244 needing incontinent care on 5/6/2024, she did not want therapy. PTA #1 stated her schedule on 5/6/2024 to provide therapy services to other

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residents did not allow her to go back and provide Resident #244 her therapy on 5/6/2024.

In an interview with Nurse #2 on 5/10/2024 at 3:25 p.m., she stated she answered Resident #244's call bell on the morning of 5/6/2024 and provided her incontinent care. Nurse #2 stated she was unable to recall the exact time of the morning. She said Resident #244 did not complain to her about having to wait to be changed.

In an interview with the Director of Nursing (who was present during the interview with Nurse #2) on 5/10/2024 at 3:25 p.m., she explained she was with Nurse #2 on the morning of 5/6/2024 and assisted with Resident #244's incontinent care. She stated she reminded the nurse aides about rounding every two hours on the residents for personal care and incontinent needs.

In a follow up interview with the Director of Nursing on 5/10/2024 at 5:52 p.m., she stated she didn't think Resident #244's call bell had been on that long on 5/6/2024 and she also did not think Resident #244 had been waiting 2 hours for incontinent care. She said Resident #244 did not complain about having to wait for incontinent care when she (the DON) assisted Nurse #2 with incontinent care and the adult brief was not saturated with urine. She said she was unaware Resident #244 did not receive her therapy on 5/6/2024 due to not receiving incontinent care timely or that a staff member had turned off her call bell and exited the room. She explained the needs of Resident #244 should be addressed when staff answer the call bell.

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F 689	Continued From page 9	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and family, staff and physician interviews, the facility failed to implement interventions to reduce the risk for further falls for a resident at high risk for falls for 1 of 4 residents reviewed for accidents (Resident #82). The findings included: Resident #82 was admitted to the facility on 2/26/24 with diagnoses including encephalopathy (damage or disease that affects the brain), diabetes, Crohn's disease, aphasia (difficulty expressing herself), epilepsy and epileptic syndromes (seizures), right sided paralysis, cerebral infarction (stroke), congestive heart failure, and muscle weakness. Review of Resident #82's comprehensive care plan dated 2/26/24 revealed she needed the assistance of one staff member for transfers. The care plan noted Resident #82 was at risk of falls related to cerebral infarction, muscle weakness, Crohn's Disease and Congestive Heart Failure. Interventions included to minimize risks for falls / minimize injuries, educate resident / family	F 689	1. Resident #82 discharged from facility on 6/03/24. 2. All residents with falls in the last 30 days were reviewed for interventions and checked rooms to ensure that interventions were in place. Completed 6/07/24. 3. Director of Nursing (DON)/designee completed education with all staff on fall interventions and prevention. Education will be provided to all new hires during orientation. Education completed 6/13/24. 4. DON/designee will audit all new admissions for fall risks x 12 weeks and any resident falls weekly x12 weeks to ensure that interventions are implemented to reduce falls. Results to be reported in QAPI x 3 months by the DON.	6/14/24

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regarding preventative fall interventions / safety devices as appropriate, implement preventative fall interventions / devices, maintain call bell within reach, educate resident to use call bell, maintain resident's needed items within reach, physical therapy (PT), occupational therapy (OT), and speech therapy (ST) to screen and treat as necessary per physician order, visual cues to remind resident to use call light for assistance, non-skid socks when out of bed.

Review of Resident #82's physical therapy (PT) assessment dated 2/27/24 revealed she scored a 2/28 on a balance and gait assessment which indicated she was at high risk of falls. Resident #82 needed moderate assistance for transfers with 75-90% verbal cues for safety.

Review of Resident #82's Minimum Data Set (MDS) dated 2/28/2024 revealed she had severe cognitive impairment, fluctuating disorganized thinking, and had an impairment on her upper and lower extremities on one side of her body. She was dependent on others for toileting and dressing. Transfer assistance needs were not assessed on the MDS due to medical condition or safety concerns. The MDS indicated that Resident #82 was incontinent of bowel and bladder and was not on a toileting program. Resident #82 was receiving physical therapy (PT) and occupational therapy (OT) and had not had any falls prior to or since admission. Resident #82 was not receiving an anticoagulant at the time of the assessment.

Review of Resident #82's incident report dated 4/28/24 at 11:00 AM completed by Nurse #2 revealed Resident #82 was found on the floor on the left side of her bed. She was not able to say

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what happened. The incident report noted she was confused, had gait imbalance, and was ambulating without assistance.

In an interview on 5/10/24 at 2:49 PM, Nurse #2 said she could not speak to Resident #82's fall. She said she did not work with Resident #82 often but the resident appeared that she would be able to use the call light. She said she was aware of Resident #82's falls on 4/28/24 because the nurses call her to report incidents to her.

In an interview on 5/10/24 at 2:52 PM, NA #3 said she remembered hearing Resident #82 yelling out a lot instead of using the call light. NA #3 said Resident #82 was in a room at the far end of the hallway so she had to make sure she went to the end of the hall to check on her. NA #3 said on 4/28/24, Resident #82 was found on the floor in her room. Nurse #8 assessed her and then told the NA to get the resident dressed and to bring her out to the nurses' station. NA #3 took her out to the station and then proceeded with her rounds. Before lunch was served, NA #3 said she saw Resident #82 in her room. She was sitting in her wheelchair with her feet resting on her bed. She was anxious, agitated, and fidgeted a lot. She said she asked Nurse #8 why the resident was in her room and Nurse #8 told her that she had pushed the resident back to her room because she was making too much commotion at the station wanting to go back to her room. NA #3 said Resident #28 had non-skid shoes on and the bed was in the lowest position, but she did not remember if the resident had any other fall prevention interventions in place.

In an interview on 5/10/24 at 5:10 PM, Nurse #8 (an agency nurse) said on 4/28/24, Resident #82

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was yelling out throughout the morning. Resident #82's room was at the end of the hallway away from the nurses' station. Nurse #8 said that was normal for the resident. Staff would go into the room periodically to see what she needed but the resident would just say she didn't know what she needed or how the staff could help her. At approximately 11:15 AM, Resident #82 was found on the floor on her buttocks. She assessed her and there were no injuries reported. She was put back into bed and told to use the call light. Nurse #8 said Resident #82 was confused and did not know how to use the call light or how to ask for what she needed. She indicated she put the call bell in the resident's hand because she wanted the resident to have it just in case. Resident continued to yell out so the NA brought her out to the nurses station. She continued to yell out and she (Nurse #8) attempted to calm her by explaining they had moved her to keep her safe. Resident #82 didn't stay at the station long and began to wheel herself back to her room scooting her feet to propel her down the hall. Nurse #8 said she followed the resident back to her room and sat with her for approximately 10 minutes, hoping it would make the resident less anxious. Nurse #8 remembered her bed was in the lowest position and the resident had non-skid socks on.

Review of Resident #82's incident report dated 4/28/24 at 12:10 PM completed by Nurse #25 revealed Resident #82 had a second fall on 4/28/24. She was found on the floor in her room by Nurse Aide (NA) #3. The resident was noted to be confused with an injury to the right side of her head. Nurse #8 assessed her and the resident was unable to say what happened and her response was a "word salad." Resident #28 was sent to the hospital.

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In an interview on 5/10/24 at 5:10 PM, Nurse #8 said on 4/28/24, at approximately 12:10 PM, Resident #82 was found on the floor again next to her bed on her right side. Nurse #8 assessed her and said she saw blood on the floor and a large bump on her forehead. Nurse #8 called the on-call provider, who said to send the resident to the hospital. Nurse #8 said she did not know what else could have been in place as an intervention. She said the resident did not remember how to use the call bell and didn't know what the red button on the call bell was for. Nurse #8 said she put the call bell in the resident's hand because she wanted the resident to have it just in case. She said the resident wasn't able to fully articulate her needs, so staff checked on her regularly to see if she needed anything such as food, a drink, toileting, or if she was in pain. Nurse #8 said 4/28/24 was her first shift working at the facility. She said the previous shift updated the nurse with information but at report it was not communicated to her that Resident #82 was a high fall risk. Nurse #8 said everyone on the unit was a fall risk and Resident #82 didn't stand out.

Review of Resident #82's hospital admission note dated 4/28/24 revealed she was diagnosed with a 2 millimeter subdural hematoma (bleed). While in the hospital, the neurologist ordered to treat her with conservative measures and not to perform surgery. Resident #82's Eliquis was discontinued to prevent further bleeding.

Review of Resident #82's nursing notes dated 5/2/24 revealed she was readmitted to the facility. The nursing notes indicated the resident moved to a room closer to the nurses station.

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Review of Resident #82's fall care plan revealed new interventions initiated 5/2/24 were to move her to a room closer to the nurses' station and for fall mats on the floor by both sides of the bed. An additional intervention was added on 5/7/24 for a perimeter mattress (a mattress with raised sides to help emphasize the boundaries of the bed) to be put on her bed. The intervention for non-skid strips on the floor was removed on 5/7/24.

In an interview on 5/7/24 at 04:00 PM, Resident #82's Family Member #1 and Family Member #2 said her health and cognition had been declining. The family said they had spoken with a nurse manager (name unknown) about checking on the resident at least every 1-2 hours but was told staff would not be able to do that.

In an interview on 5/9/24 at 2:35 PM, NA #4 said she had worked with Resident #82 several times before her fall on 4/28/24. She said before the fall on 4/28/24, Resident #82 would not be brought out to the nurses station by other staff members when they worked with Resident #82 but it would have helped. NA #4 said she would attempt to bring the resident out of her room and try to reorient and redirect her as needed.

In an interview on 5/9/24 at 2:42 PM, NA #5 said he had worked with Resident #82 after she readmitted on 5/2/24. He said she would try to get up out of bed on her own. He said they had interventions for her like pillows on her sides to keep her in bed safely. He said she did not use the call bell for help, that she would just yell out for help.

An observation on 5/07/24 at 3:45 PM revealed Resident #82 asleep in bed. There was an air

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mattress on the bed which did not have perimeter supports. There was a fall mat on one side of the bed (by wall) but not on the other side next to roommate.

An observation on 5/08/24 at 12:33 PM revealed Resident #82 had an air mattress on her bed which did not have perimeter supports. There was one fall mat on one side of the bed (by wall) but no fall mat on the other side of the bed.

In an interview on 5/10/24 at 3:40 PM, MDS Nurse #1 said that Resident #82's initial fall interventions were standard for all residents who admit to the facility as a fall risk. The Interdisciplinary Team (IDT) should have reviewed the care plan and interventions and updated it with every fall. She said the IDT would meet after every fall to discuss interventions. The IDT felt that adding measures such as a perimeter mattress or fall mats could have caused Resident #82 to fall so those interventions were not implemented after her seizure and before the 4/28/24 fall. MDS Nurse #1 said most of her falls were due to her wanting to go to the bathroom, even if she had just been taken by the staff. MDS Nurse #1 said the IDT had difficulty with interventions because her abilities fluctuated so much. Resident #82 had bowel concerns that would make her feel like she needed to go to the bathroom all the time which would cause her to attempt to transfer herself.

In an interview on 5/10/24, the Director of Nurses (DON) said all resident falls were discussed with the IDT, which included the nursing unit manager, an MDS nurse, the Administrator, the Social Worker, and the DON. She said other department managers would attend as needed. Fall

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F 689	Continued From page 16 interventions would be reviewed and implemented based on the resident's cognitive and functional capabilities. The root cause of Resident #82's falls were difficult to determine because they were unwitnessed and the resident did not remember any of the circumstances when questioned. An intervention that the IDT thought would benefit Resident #82 was to bring her out to a common area if she agreed, but she frequently would not allow staff to take her and they could not force her. The facility attempted bright colored tape on the call bell, but staff disagreed on if it was helpful. The DON said there were staff that thought it was beneficial and the visual reminder would help her but other staff thought "it was a waste of time." The DON said she was not aware staff felt the resident did not know what to do with the call bell even when put into the resident's hand. The IDT did not determine any kind of patterns to her falls. The DON said they could not identify any additional interventions that would have been beneficial for Resident #82. She said the interventions of the fall mats on both sides of the bed and the perimeter mattress should have been in place. In an interview on 5/10/24 at 10:00 AM, the Medical Director, who was Resident #82's primary doctor, said he was not sure why she had so many falls. He said interventions such as increased supervision could have helped prevent Resident #82's falls.	F 689		
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	F 727		6/14/24

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F 727	Continued From page 17 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 reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours per day, 7 days a week for 1 of 36 days reviewed for sufficient staffing (4/13/24). Findings included: A review of the daily nursing staffing sheets for the month of April 2024 and May 1-6,2024 indicated there was no RN scheduled for 4/13/2024. A review of the daily census posting sheets for the month of April 2024 and May 1-6, 2024 recorded there was one RN for eight hours on 4/13/2024 during the day shift (7a.m. to 3 p.m.). The census was recorded as 88 residents on 4/13/2024. There was also no RN recorded for the evening shift (3p.m. to 11p.m.) and the night shift (11p.m. to 7 a.m.) on 4/13/2024. Therefore, on 4/13/2024, there was no RN coverage for 24 hours in the facility. A review of Nurse #1's employee timecard for April 2024 showed no time punch for 4/13/2024.	F 727	1. Facility failed to have a Registered Nurse (RN) on 4/13/24. All notes, assessments, grievances and vitals were reviewed for residents on April 13. No negative outcomes were identified due to lack of RN coverage. 2. Staff schedules for the remainder of April and May were reviewed to ensure an RN was scheduled for at least 8 hours every day. Completed 6/6/24. 3. Education provided by Regional Director of Clinical Services (RDCS) to Director of Nursing (DON) and staff scheduler on importance of having RN coverage daily. Training completed 6/5/24. 4. Administrator/designee will audit schedules weekly x 12 weeks to ensure RN coverage. Results will be reported in QAPI x 3 months by the Administrator.	

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F 727	Continued From page 18 In an interview with the Scheduler on 5/10/2024 at 6:32 p.m., she stated Nurse #1 only worked weekends and should had been recorded on the daily nursing staffing sheet for April 13, 2024. She said Nurse #1 was scheduled to work 4/13/2024 and when she called out on 4/13/2024, there was not a RN available to come in to work. She explained the daily census posting sheet should had been updated to reflect there was no RN for 4/13/2024. In an interview with the Director of Nursing (DON) on 5/10/2024 at 5:27 p.m., she explained Nurse #1 (RN) who was scheduled to work on 4/13/2024 called out of work. She stated she was unable to find a RN to work on 4/13/2024 to cover the eight hours of RN coverage. She also said it was her understanding she could not serve as the eight-hour RN coverage since the census on 4/13/2024 was greater than 60 residents in the facility.	F 727		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		6/14/24

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F 757	Continued From page 19 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Medical Director (MD) interviews, the facility failed to ensure a resident did not receive anticoagulant medication (blood thinner) that had been discontinued for a resident with a subdural hematoma (brain bleed) and at risk for falls for 1 of 3 residents reviewed for unnecessary medications (Resident #82). The findings were: Resident #82 was admitted to the facility 2/26/24 with diagnoses including epilepsy and epileptic syndromes, hemiplegia and hemiparesis affecting right dominant side, and cerebral infarction (stroke). Review of Resident #82's hospital discharge note dated 5/02/24 revealed she was diagnosed with a 2 millimeter subdural hematoma (brain bleed). While in the hospital, Resident #82's Eliquis was discontinued to prevent further bleeding. Review of Resident #82's physician's orders revealed she was taking Eliquis (a blood thinner) 2.5 mg twice a day. The order was discontinued on 5/2/24. There were no orders to restart the medication.	F 757	1. Resident #82 □ Facility transitioned to new Electronic medication administration record (EMAR) system on 5/06/24 and order for Eliquis had not been discontinued in the new system prior to transition date. It was discontinued on 5/10/24 when facility staff made aware of situation. Resident #82 discharged on 6/03/24. 2. Regional Director of Clinical Services (RDCS) audited all resident medication orders and compared to medication orders in Point Click Care (old EMAR system) to ensure accuracy. Completed 5/30/24. 3. On 6/06/24, RDCS educated Director of Nursing (DON) and unit manager on Matrix transition and order management. All new nurse management staff will be educated on order management reports and compliance during orientation. Education completed 6/06/24. 4. RDCS/designee will audit all current and new residents with anticoagulant orders for accuracy in morning clinical meeting for 12 weeks. Results of audits will be reported in QAPI x 3 months by the DON.	

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F 757	Continued From page 20 Review of Resident #82's electronic Medication Administration Record (eMAR) for May 2024 on 5/10/24 revealed she was being administered the Eliquis twice a day starting on 5/6/24 through 5/10/24. In an interview on 5/10/24 at 4:52 PM, the Director of Nurses (DON) said when the electronic medical records system was changed, medication orders and eMAR were reconciled by management including corporate management. The DON was not sure how the medication was added back to the eMAR and missed. Resident #82's medication should have been removed from the medication cart when she went to the hospital on 4/28/24 so it would not have been available to give. Staff should have caught that the medication was being given though it had been discontinued. In an interview on 5/10/24 at 10:00 AM, the Medical Director said Eliquis was discontinued after Resident #82 returned from the hospital after sustaining a subdural hematoma and should not have been given the medication due to her high risk of falls. He said there have been medication discrepancies once the pharmacy changed over the medication orders from the old eMAR system to the new system. The pharmacy had used old orders instead of updating with the most current orders.	F 757		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		6/14/24

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F 759	Continued From page 21 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, pharmacy interview and Physician interview, the facility failed to have a medication error rate less than 5% as evidenced by 6 medication errors out of 29 opportunities, resulting in a medication error rate of 20.69% for 1 of 2 residents observed during the medication administration observations. Finding included: Resident #76 was admitted to the facility on 4/15/2024 with diagnoses including chronic respiratory failure, Myasthenia Gravis (an autoimmune condition that causes muscle weakness that gets worse with activity and better with rest), anxiety disorder and atrial fibrillation (irregular heart rate). The admission Minimum Data Set (MDS) dated 4/21/2024 indicated Resident #76 was cognitively intact was using a gastrostomy tube (a devices surgically placed in the stomach for supplemental feeding, hydration and medications) for a nutritional approach Physician's orders included the following medications for Resident #76: * Amiodarone HCL (used to treat irregular heartbeat) 200 milligram (mg) once a day via gastrotomy tube (g-tube). * Apixaban (a blood thinner) 5mg via g-tube twice a day for atrial fibrillation. *Glycopyrrolate (used to treat lung disease) 1 mg via g-tube four times a day for secretions.	F 759	1. Resident #76 discharged from facility on 5/09/24. 2. All residents with gastrostomy tubes are at risk for deficient practice. Regional Director of Clinical Services (RDCS) reviewed all residents with G-tubes on 6/05/24 to ensure there physician orders to either bolus medications for administration or to give medications individually based on physician review. Audit of physician orders for administration was completed 6/05/24 with only 2 residents residing in facility with G-tubes. 3. Medication administration competencies were completed for all nurses by Director of Nursing (DON)/designee. Nurses will not be able to return to work until competency is completed. Education will be provided to all new hires during orientation. Education completed 6/13/24. 4. DON/designee will audit 2 nurses weekly x 12 weeks to ensure compliance. DON to report results in QAPI x 3 months.	

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* Vitamin D (nutrient that builds healthy bones) 25 micrograms (mcg) via g-tube once a day for health maintenance.
*Lorazepam (antianxiety medication) 0.5mg tablet via g-tube every 8 hours as needed for anxiety.
* polyethylene glycol powder (a laxative) 17 grams (gm) via g-tube once a day for constipation.

Nurse #5 was observed on 5/8/2024 at 7:43 a.m., during medication administration for Resident #76, placing 17 gm of polyethylene glycol powder in a 8-ounce drinking cup and crushing together the following medications and placing in a medication cup: Amiodarone 200 mg tablet, Apixaban 5 mg tablet, Glycopyrrolate 1mg tablet, Vitamin D 25 mcg tablet and Lorazepam 0.5mg tablet. Nurse #5 then added a half cup of water (approximately 120 milliliters) into the polyethylene glycol powder and mixed the crushed medications into the laxative solution. Nurse #5 flushed Resident #76's g-tube with 30 milliliters of water, administered the MiraLAX and crushed medications solution through the gastrotomy tube and flushed the g-tube with 30 milliliters of water.

Nurse #5 stated on 5/8/2024 at 7:56 a.m. that when the physician had reviewed Resident #76's medications and it was not contraindicative to give the medications together.

In an interview with Nurse #5 on 5/9/2024 at 5:14 p.m., she stated Resident #76's medications could be safely administered at one time unless there was a physician order stating differently. She explained Resident #76's medications had been reviewed by the pharmacy staff and she was not aware of any contraindication with the

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F 759	Continued From page 23	F 759		

medications crushed and administered together. She explained she administered the medications together because she misunderstood the order to give all medications by the g-tube as giving all medications at one time. She stated based on the facility's policy; she administered the medications wrong. She explained she should have administered Resident #76's medications one medication at a time flushing before and after each medication.

In an interview with the Director of Nursing on 5/9/2024 at 5:50 p.m., she explained Resident #76's medications administered by Nurse #5 should have been individually crushed and dissolved in water and administered individually with flushes of 15 milliliters of water before and after each medication via the g-tube per the facility's policy.

In a phone interview with the Pharmacist #1 on 5/10/2024, she explained the medications crushed together would not have caused a drug reaction. She stated the medications should have been individually crushed, dissolved, administered separately and not dissolved in the polyethylene glycol powder and water.

In an interview with Physician #1 on 5/9/2024 at 5:30 p.m., he stated his signature on Resident #76's orders represented he had reviewed the orders and did not imply to give all medications together. He explained medications could be crushed, dissolved in water and administered one at a time. He stated medications should not be mixed in the polyethylene glycol powder and water, and it was not recommended to crush and mix medications together. After reviewing Resident #76's orders, he stated there was no

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F 759	Continued From page 24 order to crush medications and administer medications together via the gastrotomy tube on Resident #76's electronic medical record.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain kitchen equipment in a clean and sanitary condition to prevent cross contamination by failing to clean under the shelf of 1 of 1 steam table observed. This practice had the potential to affect food served to the residents in the facility. The findings included: During an observation of the kitchen on 5/08/24	F 812	1. On 5/8/24 surveyor noted debris on bottom side of steam table shelf. Steam table shelf was cleaned on 5/10/24 right after observation and discussion with surveyor. 2. Regional Registered Dietician completed a thorough audit of kitchen equipment on 5/10/24 to ensure cleanliness. No other deficient practices found. 3. Regional Registered Dietician educated	6/14/24

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F 812	Continued From page 25 at 8:36 AM, the five well steam table was observed with dark dried food particles under the 5-foot steam table shelf. During an observation of the kitchen on 5/10/24 at 8:23 AM, the five well steam table was observed with dark dried food particles under the 5-foot steam table shelf. In an interview with the Dietary Manager on 5/10/24 at 8:39 AM, he indicated he would have staff clean the steam table shelf and start a daily check of the area. In an interview on 5/10/24 at 12:34 PM, the Administrator indicated he would expect the kitchen staff to clean the steam table shelf.	F 812	dietary manager on cleaning of kitchen equipment and expectations. Education completed 5/10/24. 4. Administrator/designee will audit kitchen equipment weekly x 12 weeks to ensure cleaning schedules are maintained for food procurement and serving areas. Results to be reported in QAPI x 3 months by Administrator.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the area surrounding the one dumpster on the campus was free of debris and the dumpster door was closed for 2 or 2 observations. The findings included: During an observation of the dumpster area on 5/08/24 at 8:10 AM, the dumpster door was open with one disposable glove and one clear plastic trash bag observed beside the dumpster. During an observation of the dumpster area on	F 814	1. Trash compactor door was noted to be open on 5/06/24 and again on 5/10/24. Door was immediately closed by dietary manager on both dates. Debris removed from area surrounding dumpster on 5/10/24. 2. Dietary manager observed door to ensure it remained closed after each use for the remainder of the week. No other deficient practice found. 3. Administrator/designee completed education with all staff. Education completed 6/13/24. 4. Dietary Manager/designee will perform	6/14/24

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F 814	Continued From page 26 5/10/24 at 10:02 AM, the dumpster door was open with one disposable glove, and one clear plastic trash bag observed beside the dumpster. An observation was conducted with the Dietary Manager on 5/10/24 at 10:17 AM and the dumpster area was observed to be in the same condition (with one disposable glove, and one clear plastic trash bag observed beside the dumpster). In an interview on 05/10/24 at 10:17 AM, the Dietary Manager revealed kitchen staff shared responsibility with housekeeping staff to keep the dumpster area clean and door closed. In an interview on 5/10/24 at 12:34 PM, the Administrator indicated he would remind all staff to close the dumpster door.	F 814	random audits of garbage dumpster doors and surrounding areas weekly x 12 weeks. Results to be reported in QAPI x 3 months by Dietary Manager.	
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on record review, North Carolina Board of Nursing (NCBON) verification registry and staff interviews, the facility failed to verify a staff member working as a nurse (Nurse Aide #7) had an active professional nursing license with the	F 839	1. Nurse aide that was discovered to not have a valid nursing license no longer works at facility and last worked in February 2023. 2. All nurse, medication aide, and certified	6/14/24

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F 839	Continued From page 27 NCBON for 1 of 4 nursing staff reviewed. NA #7 was in nursing school, did not have a professional nursing license and performed the job responsibilities of a nurse. Findings included: A review of NA #7's application with the facility indicated she was hired as a Nurse Aide on 6/23/2022 and was attending school for nursing. The North Carolina Health Care Professional Registry (NCHCPR) validation inquiry dated 6/30/22 indicated NA #7's Nurse Aide I Registry listing expired on 6/30/2023. NA #7 was not listed as a North Carolina Medication Aide on the NCHCPR. An Employee Change of Status form dated 7/31/2022 indicated a promotion for NA #7, and the employment status change was due to NA #7 receiving a licensed practical nursing (LPN) license. There was no LPN licensure verification for NA #7 located in NA #7's employment record. A review of the daily nurse staffing sheets since the last recertification survey on 1/6/2023 recorded NA #7 was assigned as a nurse to the front of the 200-hall on the following days: 1/9/2023, 1/15/2023, 1/18/2023, 1/19/2023, 1/23/2023, 1/27/2023, 1/28/2023, 1/29/2023, 2/1/2023, 2/2/2023, 2/6/2023, 2/10/2023, 2/11/2023 and 2/12/2023. A review of NA #7 timecard report for January 2023 and February 2023 recorded NA #7 worked the following hours on the following days:	F 839	nursing assistant (CNA) licenses were audited to ensure there is a current, valid license on file by Human Resources director. Completion date: 5/21/24. 3. All new hire licenses are now verified prior to hire. All existing licensed staff are now verified monthly and current copy of licensure is placed in a binder in human resources and Director of Nursing office. 4. Administrator will audit 5 random licenses monthly x 3 months to ensure compliance. Administrator to report results in QAPI x 3 months.	

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F 839	Continued From page 28	F 839		

*1/9/2023: 6:44 am to 6:55 pm.
*1/15/2023: 6:45 am to 7:00 pm.
*1/18/2023: 6:45 am to 7:00 pm.
*1/19/2023: 6:44 am to 7:04 pm.
*1/23/2023: 6:43 am to 6:55 pm.
*1/27/2023: 6:42 am to 7:05 pm.
*1/28/2023: 6:46 am to 6:58 pm.
*1/29/2023: 6:44 am to 6:49 pm.
*2/1/2023: 6:47 am to 6:42 pm.
*2/2/2023: 6:51 am to 6:53 pm.
*2/6/2023: 6:45am to 6:49 pm.
*2/10/2023: 6:45am to 6:57 pm.
*2/11/2023: 6:46 am to 7:36 pm.
*2/12/2023: 6:45 am to 7:05 pm.

Nursing documentation by NA #7 in the medical records of Resident #2, Resident #13 and Resident #42 recorded medications in January 2023 and February 2023 were administered by a LPN (NA #7) and nurse's notes were created and signed by NA #7 as a LPN.

A North Carolina Board of Nursing (NCBON) licensure verification dated 6/15/2023 located in NA #7 's employment folder indicated there were no results matching the criteria for NA #7 as a LPN.

On 5/9/2024 at 10:47 a.m., the computerized NCBON licensure verification listed no past or present LPN licensure or registered nurse licensure for NA #7. The computerized NCHCPR listed NA #7 as a Nurse Aide I with an expiration date of 6/30/2023.

In a phone interview with NA #7 on 5/9/2024 at 11:00 p.m., NA #7 explained she no longer worked at the facility and her last day was sometime in February 2023 as a Nurse Aide.

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F 839	Continued From page 29	F 839		

When asked if she ever worked on the medication cart for the residents on the front 200-hall, she stated as a medication aide. When NA #7 was asked why the Medication Administration Records (MAR) and nurse's notes were signed as NA #7 with the title of LPN, she explained there were members of the staff at the facility that knew she was not licensed as a LPN and was in nursing school. She said they (members of the staff) asked her to work the medication cart because the facility was short staffed. NA #7 stated she was not licensed as a medication aide or LPN when assigned to the medication cart.

In an interview with Nurse #2 on 5/7/2024 at 5:53 p.m., she stated NA #7 was hired as a nurse aide and in August 2022 her status changed to LPN status. She stated NA #7 informed the facility she had passed nursing school, and NA #7 was trained by other nurses on the medication cart. Nurse #2 stated that NA #7 worked performing LPN duties (implementing physician orders, documenting resident care, tube feeding, intravenous therapy, tracheostomy care, dressing changes) while employed at the facility. Nurse #2 explained NA #7 's employment ended after she stopped reporting to work in February 2023. Nurse #2 stated she was not aware NA #7 was not a LPN.

In an interview with the Administrator on 5/9/2024 at 6:15 p.m., he explained corporate's Human Resource Generalist was notified on 6/15/2023 by an unknown staff member alleging NA #7, who was a nurse aide, worked as a LPN. He stated he had been the facility's Administrator since December 2023, and the administration team of August 2022 did not ensure NA #7 was licensed

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F 839	Continued From page 30 as a LPN licensure before scheduling her LPN duties in the facility.	F 839		
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; (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,	F 842		6/14/24

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F 842	Continued From page 31 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; (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 record review, resident interview, staff interviews and Physician #1 interview the facility failed to complete an accurate medical record in documenting blood glucose (sugar) levels and sliding scale insulin coverage of blood glucose levels (Resident #66), the administration of enteral feedings (Resident #76), and the	F 842	1. Resident #76 discharged and #245 discharged on 4/07/24. Resident #66 □ documentation prompts were added to insulin orders for blood sugar results, site of administration, and number of units given on 5/09/24. Pharmacy consulted for availability of Trulicity and new order was	

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F 842	Continued From page 32 administration of medications (Resident #66, Resident #76 and Resident #245) for 3 of 10 residents whose medication regimen was reviewed. Findings included: 1. a. Resident #66 was admitted to the facility on 10/31/2023 with diagnoses including Diabetes Mellitus. Physician's orders dated 12/18/2023 included an order for Humalog (fast acting insulin that lowers the blood glucose level) injection Solution 100 units/milliliter per sliding scale insulin subcutaneously before meals and at bedtime for Diabetes Mellitus. The sliding scale instructions for administration were the following: *If Blood Sugar was 71 to 150, give 0 Units. *If Blood Sugar was 151 to 200, give 2 Units. *If Blood Sugar was 201 to 250, give 4 Units. * If Blood Sugar was 251 to 300, give 6 Units. *If Blood Sugar was 301 to 350, give 8 Units. * If Blood Sugar was 351 to 400, give 10 Units. * Call the Physician if glucose level was less than 70 and/or greater than 400. Resident #66's May 2024 Medication Administration Record (MAR) indicated the blood glucose levels were scheduled daily at 7:00a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. on an electronic medical record system (EMR) used at the facility prior to 5/6/2024 with Humalog sliding scale coverage and was scheduled for 7:30 a.m. only on the new EMR system after 5/6/2024 with Humalog sliding scale insulin. The new EMR system recorded a nurse's signature only indicating Resident #66's blood glucose levels with Humalog sliding scale insulin at 7:30 a.m. on	F 842	received to give Resident #66 Ozempic. 2. All current diabetics with insulin were reviewed by Regional Director of Clinical Services (RDCS) on 6/05/24 and orders were reviewed to ensure proper documentation requirements were on all insulin orders. All diabetic residents were also reviewed on 6/04/24 to ensure there were no other residents receiving Trulicity none at this time reside in facility. All current residents with enteral feedings were reviewed on 6/05/24 no other residents currently receive enteral feedings in the facility at this time. 3. On 6/05/24, Regional Director of Clinical Services (RDCS), provided education to the Director of Nursing (DON) and Unit Manager (UM) on how to pull a report in new electronic charting system for missed or late medication administrations. DON and UM instructed to follow up on this report daily to ensure timely medication administration and accuracy. All current nurse staff were educated on charting medications/enteral feedings in a timely matter each shift and how to put in insulin orders for new Matrix charting system by DON and UM on 6/13/24. All new hires will be trained during orientation. 4. DON/designee will audit all new admissions weekly x 12 weeks to ensure all diabetic residents (receiving insulin) have accurate supplemental documentation in their orders to include blood sugar monitoring, number of units given and site administered. DON/designee will run a medication compliance report during clinical meeting	

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F 842	Continued From page 33 5/7/2024, 5/8/2024, 5/9/2024 were performed. There were no blood glucose levels recorded or administration of Humalog sliding scale insulin documented. The May 2024 MAR recorded a change for scheduled blood glucose levels with Humalog sliding scale insulin coverage before meals and at bedtime on the May 2024 MAR by the new EMR system on 5/9/2024 at 4:00 p.m. On 5/9/2024 at 4:00 p.m. Resident #66's blood glucose reading was recorded as 400 and 10 units of Humalog Sliding scale insulin was administered and physician was notified. After the change, the May 2024 MAR had Resident #66's daily blood glucose levels with Humalog sliding scale insulin scheduled for 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. There were no blood glucose levels or administration of Humalog sliding scale insulin for Resident #66 on the following dates: *5/6/2024 at 8:00 p.m. *5/7/2024 at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. *5/8/2024 at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. *5/9/2024 at 7:00 a.m., 11:00 a.m. In a phone interview with Resident #66 on 5/24/2024 at 1:48 p.m., he stated the nursing staff had been conducting blood glucose levels four times a day before meals and at bedtime and covered with Humalog sliding scale insulin as needed. In a phone interview with Nurse #5 on 5/24/2024 at 2.09 p.m., she said when she was assigned to Resident #66 on 5/8/2024 and 5/9/2024 on the day shift (7: 00 a.m. to 7:00 p.m.), she conducted his blood glucose levels before meals and	F 842	x 12 weeks to ensure that medications are given timely and that there are no missed documentation opportunities. DON/designee to report results of these audits monthly in QAPI meeting x 3 months.	

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covered with Humalog sliding scale insulin per physician order. She stated she documented conducting his blood glucose levels and administration of the Humalog sliding scale inulin on the new electronic MAR system under the order. She explained she did not document the blood glucose level and the amount of Humalog sliding scale administered on the new electronic MAR system on 5/8/2024 and 5/9/2024 because there was no space on the system to document the blood glucose level and the amount of Humalog sliding scale administered until the order was changed on 5/9/2024.

In a phone interview with Nurse #6 on 5/24/2024 at 3:10 p.m., she explained she was familiar with Resident #66 and his blood glucose level schedule. She stated when she was assigned to Resident #66 on 5/7/2024 on the day shift (7: 00 a.m. to 7:00 p.m.), she conducted his blood glucose levels as ordered before meals. She stated she would have documented conducting his blood glucose level and administration of Humalog sliding scale insulin as needed on the new electronic MAR system as scheduled at 7:30 a.m. She explained when Resident #66's blood glucose levels were checked before meals, Humalog sliding scale insulin was given as needed. She said she did not recall anywhere on the new electronic MAR to document the blood glucose levels or the Humalog sliding scale insulin and did not document the blood glucose levels or the amount of Humalog sliding scale insulin given in the nurse progress notes.

In a phone interview with Nurse #13 (who was assigned to Resident #66 on 5/6/2024 from 7:00 p.m. to 7:00 a.m.) on 5/24/2024 at 3:32 p.m., she stated she checked Resident #66's blood glucose

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level on 5/6/2024 at bedtime. She explained according to her worksheet from 5/6/2024 7:00 p.m. to 7:00 a.m., his blood glucose reading was 315 and Humalog sliding scale insulin was administered as ordered. She explained she was checking between the old electronic MAR system and the new electronic MAR system that night to ensure Resident #66 received all his medications. She said she was still learning the new electronic MAR system and could not recall documenting Resident #66's bedtime blood glucose level or administration of Humalog sliding scale insulin on the new electronic MAR system or in the nurse progress notes.

Attempts to reach Nurse #4, who was assigned to Resident #66 on 5/7/2024 from 7:00 p.m. to 7:00 a.m. were unsuccessful.

In a phone interview with Nurse #14 (who was assigned to Resident #66 on 5/8/2024 from 7:00 p.m. to 7:00 a.m.) on 5/24/2024 at 2:21 p.m., she stated she recalled checking Resident #66's blood glucose level on 5/8/2024 at bedtime. She explained until the new electronic MAR system Resident #66 was scheduled a blood glucose check at bedtime and in the morning before he ate breakfast. She said checking the before breakfast blood glucose level changed to the day shift (7: 00 a.m. to 7:00 p.m.). She stated she documented the blood glucose level in the new electronic MAR system and Humalog sliding scale insulin coverage and was not able to explain why it was not recorded in the new electronic MAR system.

In an interview with the Director of Nursing on 5/10/2024 at 1:55 p.m., she explained the blood glucose level and Humalog sliding scale order did

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not transfer into the new electronic MAR correctly with the changing of EMR systems on 5/6/2024 and the facility reviewed Resident #66's orders and MARs for accuracy on 5/9/2024. In a follow up phone interview with the Director of Nursing on 5/28/2024 at 5:02 p.m., she stated she had not been able to locate documentation of blood glucose levels and administration of Humalog sliding scale insulin from 5/6/2024 at 8:00p.m. to 5/9/2024 at 11:00 a.m. in the new electronic MAR system for Resident #66 because there was no place to record the blood glucose level and administration of Humalog sliding scale insulin when the new electronic MAR system started on 5/6/2024. She stated since 5/24/2024, the facility had added blood glucose levels and the administration of Humalog sliding scale insulin to Resident #66's medical record based on information from the nurse's worksheets. She stated the nursing staff should Resident #66's blood glucose level and administration of Humalog sliding scale insulin in the new electronic MAR system or nursing progress notes.

In a phone interview with Physician #1 on 5/28/2024 at 12:00 p.m. he stated the nursing staff needed to document in Resident's #66 electronic medical record blood glucose levels and administration of Humalog sliding scale insulin when performed.

b. Physician's orders dated 11/28/2023 included Trulicity 3 milligrams per 0.5 milliliter injections subcutaneously one time a day every seven days for Diabetes Mellitus.

The quarterly Minimum Data Set (MDS) assessment dated 2/20/2024 indicated Resident

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#66 was cognitively intact and was receiving hypoglycemic medications.

The Medication Administration Record for April 2024 for Resident #66 did not record Trulicity was administered as scheduled on 4/3/2024 and 4/24/2024. The last dose recorded given on the April 2024 MAR was on 4/17/2024.

There was no documentation in the nursing notes that Resident #66 had received Trulicity on or around 4/3/2024 and 4/24/2024.

The Medication Administration Record for May 2024 for Resident #66 did not record Trulicity was administered on 5/1/2024 and 5/7/2024 as scheduled or any time from 5/1/2024 to 5/10/2024.

There was no documentation in the nursing notes that Resident #66 had received Trulicity from 5/1/2024 to 5/10/2024.

In a phone interview with Resident #66 on 5/24/2024 at 1:48 p.m., he stated he had received his medication, Trulicity, weekly. He explained sometimes it was administered on Wednesday (the day it was scheduled) or on Thursday.

In a phone interview with Nurse #5 on 5/24/2024 at 2:09 p.m., she stated when she was assigned to Resident #66 on 4/24/2024, 5/1/2024 and 5/8/2024, the medication, Trulicity was not available to administer as scheduled at 8:00 a.m. She explained the medication, Trulicity, was ordered from the pharmacy and was given to Resident #66 when the medication arrived at the facility. Nurse #5 explained the medication, Trulicity, did not always arrive from pharmacy

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during her shift, so therefore, the next shift nurse assigned to Resident #66 would have to give the medication. She stated when she administered Resident #66's his Trulicity after receiving from pharmacy, she didn't document in Resident #66's medical record the exact time when the medication was administered.

In a phone interview with Nurse #14 (who was assigned to Resident #66 on 5/8/2024 from 7:00 p.m. to 7:00 a.m.) on 5/24/2024 at 2:21 p.m., she explained the medication, Trulicity, was scheduled for administration on the day shift (7:00 p.m. to 7:00 p.m.) and there was no need for the night shift (7:00 p.m. to 7:00 a.m.) to administer the medication. She said she did not administer the medication, Trulicity, during her shift on 5/8/2024.

In a phone interview with Nurse #15 on 5/24/2024 at 4:21 p.m., she stated she was unable to recall if the medication, Trulicity, was available to administer on 4/3/2024. She explained if the medication was available she would have administered and signed the electronic MAR as documentation as the medication was given. She stated when medication was not available, pharmacy was notified so the medication could be sent to the facility. She explained if the order to give Trulicity on 4/3/2024 was still visible on the electronic MAR when the medication arrived from pharmacy, she would have been able to sign as administered on the electronic MAR. She also explained if unable to sign the medication was administered on the electronic MAR, a new order had to be created to document administration of the medication or documented in the nurse progress notes. She was unable to explain why there was no documentation for the

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administration of Trulicity on 4/3/2024.

In an interview with the Director of Nursing (DON) on 5/10/2024 at 1:55 p.m., she stated she was not aware that Resident #66's had not received Trulicity as scheduled. In a follow up phone interview on 5/28/2024 at 5:02 p.m., the DON said documentation of the medication, Trulicity, was to occur when the medication was administered by the nurse on the electronic MAR.

In an interview with Physician #1 on 5/10/2024 at 12:00 p.m., he stated Resident #66's Trulicity medication needed to be administered weekly as ordered and stated he was not aware Resident #66 had not received the medication. In a follow-up interview with Physician #1 on 5/28/2024 at 12 p.m., he stated documentation of the administration of Resident #66's medication, Trulicity, was to be recorded when Resident #66 actually received the medication in his electronic medical record

2. Resident #76 was admitted to the facility on 4/15/2024 with diagnoses including dysphagia (difficulty swallowing).
Physician's orders dated 4/15/2024 included an enteral feeding infusion via a gastrotomy tube at 80 milliliters per hour from 6:00 p.m. to 10:00 a.m. daily.

Resident #76's April 2024 and May 2024 Medication Administration Records (MAR) indicated on 4/28/2024 and 5/3/2024 she did not receive an enteral feeding as ordered.

In a phone interview with NA #2 (who also worked as a medication aide) on 5/10/2024 at 11:32 a.m., she stated she was assigned to Resident #76 on

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4/28/2024 and 5/3/2024. She explained the reason the enteral feeding was not documented administered on the April 2024 and May 2024 MARs was because the enteral feeding was administered by the next shift (7:00 p.m. to 7:00 a.m.) nurse. Due to working on transferring other residents out of the facility on 4/28/2024 and 5/3/2024, the enteral feeding had for Resident #76 had not been started and she was told by the next shift (7:00 p.m. to 7:00 a.m.) nurse that she would start the administration of Resident #76's enteral feeding.

In a phone interview with Nurse #13 on 5/10/2024 at 11:29 a.m., she explained she worked the 7:00 p.m. to 7:00 a.m. shift and usually when reporting to work Resident #76's enteral feeding was connected and infusing. She explained on 4/28/2024 and 5/3/2024 she started the enteral feedings for Resident #76 because the nursing staff assigned to Resident #76 was busy transferring another resident out to the hospital. She explained due to the enteral feeding scheduled for administration at 6:00 p.m. during the day shift on the MAR, documentation of the enteral feeding did not appear on her electronic MAR to document starting the administration of the enteral feeding for the night shift staff.

In an interview with the Director of Nursing on 5/10/2024 at 12:53 p.m., she stated Resident #76's enteral feeding should be documented as administered on the MAR after the enteral feeding was started.

3. Resident #245 was admitted to the facility on 4/4/2024 with diagnoses including a stroke. Resident #245 left the facility on 4/7/2024.

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The discharge Minimum Data Set (MDS) assessment dated 4/7/2024 indicated Resident #245 was cognitively intact and received antianxiety medications, hypnotic (to produce sleep) medications.

A review of the physician's orders dated 4/4/2024 included the following orders:
* Sacubitril-Valsartan (used to treat heart failure) 24-26 milligrams (mg) at bedtime for hypertension (Hold for systolic blood pressure less than 110.)
*Metoprolol Succinate Extended Release 24-hour 25 mg for atrial fibrillation.
* Torsemide 20 mg tablet. Give 3 tablets (60mg) three times a day every Tuesday, Thursday, Saturday, Sunday for hypertension.
* Buspirone HCl 5 mg every 12 hours for anxiety.
* Zolpidem Tartrate 5 mg in the evening for insomnia.
* Mirtazapine 15 mg in the evening for insomnia.

A review of the April 2024 Medication Administration Record (MAR) recorded Resident #245 received the following medications scheduled for 8:00p.m. on 4/4/2024: Metoprolol Succinate Extended Release 24-hour 25 mg tablet, Mirtazapine 15 mg tablet, Sacubitril-Valsartan 24-26mg tablet, Zolpidem Tartrate 5 mg tablet, Buspirone HCl 5 mg tablet. Torsemide 60mg was scheduled for10:00 p.m. on 4/4/2024.

A review of Resident #245 Medication Administration Audit report for 4/4/2024 recorded the medications Succinate Extended Release 24-hour 25 mg tablet, Metoprolol Succinate Extended Release 24-hour 25 mg tablet, Mirtazapine 15 mg tablet and Zolpidem Tartrate 5

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mg tablet, Buspirone HCl 5 mg tablet that were scheduled for administration at 8:00 p.m. were documented as given at 10:50 p.m. Torsemide 60mg was recorded as administered at 10:50 p.m.

In a phone interview with Nurse #4 on 5/10/2024 at 12:45 p.m., she stated Resident #245's medications scheduled for 8:00 p.m. were recorded administered at 10:50 p.m. on 4/4/2024 because she would administer the medications within the scheduled time frame on the MAR and then document on Resident #245's electronic MAR the medications were administered after all residents had received their medications. She explained she should have documented Resident #245's medications on the electronic MAR after the medications were administered.
In an interview with the Director of Nursing on 5/10/2024 at 12:53 p.m., she stated Nurse #4 was to document administration of Resident #245's medications at the time administration of the medications were completed.