STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 The survey team entered the facility on 07/08/24 to conduct a recertification survey and complaint investigation and exited on 07/11/24. Additional information was obtained from 07/18/24 through 07/23/24. Therefore, the exit date was changed to 07/23/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PLEX11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 07/08/24 to conduct a recertification survey and complaint investigation and exited on 07/11/24. Additional information was obtained from 07/18/24 through 07/23/24. Therefore, the exit date was changed to 07/23/24. Event ID #PLEX11. The following intakes were investigated: NC00215757, NC00215913, NC00216121, NC00217249, NC00217012, and NC00218915. Intake NC00213930 resulted in immediate jeopardy at past non-compliance. 3 of the 7 complaint allegations resulted in deficiency. Past Non-Compliance was identified at: CFR 483.25 at tag F693 at a scope and severity (J) Tag F693 constituted Substandard Quality of Care. Immediate Jeopardy began on 01/24/24, was	F 000		

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

Electronically Signed | 08/16/2024

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F 000	Continued From page 1 removed on 02/16/24, and the tag was corrected on 02/16/24. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		8/21/24

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to maintain a resident's dignity when Medication Aide #1 "flicked" a severely cognitively impaired resident's forehead with her finger during resident care. A reasonable person expects to be treated in a respectful and dignified by their caregivers in their home environment. This deficient practice was for 1 of 1 resident reviewed for dignity (Resident #19). Findings Included: Resident #19 was admitted to the facility on 09/28/23 with diagnoses which included dementia. Resident #19's Minimum Data Set assessment dated 06/06/24 and 10/04/24 specified the resident's cognition was severely impaired and she had physical behavioral symptoms directed toward others on 4-6 days per week but less than daily. A review of the Facility Investigation (5-day report) dated 04/18/24 was completed by the Administrator for an incident that occurred on 04/10/24 indicated Nurse Aide (NA) #4 and NA #5	F 550	Resident #19 was assessed for injuries and seen by psych services on 4/17/2024. The RP was notified of the incident. Resident remained at baseline. All alert and oriented residents were interviewed as it relates to resident rights and dignity by the DON or designee on 4/13/2024. All cognitively impaired residents were assessed for signs of abuse or mistreatment by the DON or designee on 4/13/2024. All staff were educated by the Director of Nursing or designee on 4/13/2024 on Abuse, Neglect, Resident Rights and dignity. The Director of Nursing or designee will interview 5 alert and oriented residents weekly for 12 weeks on staff treatment, resident rights or dignity issues and assess 5 cognitively impaired residents weekly for 12 weeks. The audits will be reviewed by the Quality Assurance Performance Improvement Committee for 3 months. The plan of correction may be altered, or audits extended to ensure ongoing compliance.	

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F 550	Continued From page 3	F 550		

attested to Medication Aide (MA) #1 finger thumping or flicking Resident #19 in the forehead. When interviewed, MA #1 admitted to the flicking action but stated it was in a joking manner. The NAs confirmed hearing and seeing contact, as well as both recalling the resident exclaimed "Ouch. What in the h*** did you do that for?" All employees involved were suspended until testimonies were collected and reeducation completed for the two nursing aides. MA #1 was terminated.

Review of NA #5's written statement dated 04/11/24 revealed NA #5 came into the room (on 04/10/24) to help NA #4 get Resident #19 cleaned up because she spread feces everywhere, including all over her hands and legs. MA #1 came down to help. NA #5 indicated she was standing beside the resident cleaning her hands when she witnessed MA #1 "what looked like she [MA #1] thumped resident on the head and said, you [Resident #19] should know better" and the resident said, "ouch, why the hell did you do that?" She was looking at MA #1 while rubbing the spot on her head.

An interview was conducted on 07/10/24 at 3:10 PM with NA #5. She said on 04/10/24 from 3:00 PM until 11:00 PM she worked on 600 and 700 halls with NA #4. She stated on 04/10/24 around 10:00 PM Resident #19 had a large bowel movement (BM) and was wandering within her room, a normal behavior for her, smearing BM everywhere. She and NA #4 went to clean up the resident and MA #1 came to help. The aide said the MA told the resident, "You know better than to smear your BM around like that" and flicked her on the forehead. She reported the resident responded by saying, "Why did you do that?" NA

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F 550	Continued From page 4	F 550		

#5 said she did not know why MA #1 flicked the resident's forehead. NA said the resident's wandering behavior in her room was normal, but smearing BM was not normal for her as far as she knew.

An interview was conducted on 07/10/24 at 3:00 PM with NA #4. She said on 04/10/24 from 3:00 PM to 11:00 PM she worked on 600 and 700 halls with NA #5. She said, around 10:30 PM they were both in Resident #19's room cleaning her up after a large bowel movement. She said while they were in the process of cleaning up the resident, MA #1 peeked into the room with an armful of towels and noticed that the resident had spread her bowel movement all over the room. NA #4 said MA #1 walked into the room and flicked the resident on the forehead, which the resident replied, "What in the h--- did you do that for?" NA #4 stated after that, they all three proceeded to clean up the resident and her room. NA #4 verified she saw MA #1 flick Resident #19 in the forehead and was not sure why she flicked her. Before, the MA flicked the resident on the forehead, the resident had been wandering around in her room, a normal behavior for her, and smeared feces over everything she could touch, which she had not done before.

An interview was conducted on 07/10/24 at 1:00 PM with Resident #19. She said, she remembered MA #1 came into her room (on 4/10/24) with towels to help the other two aides (NA #4 and NA #5) clean her up after she had a bowel movement. Resident #19 said when MA #1 entered her room the MA flicked her middle finger on her forehead, and she responded back to the MA, saying, "What the he** did you do that for?" The resident said it did not hurt, and she

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F 550	Continued From page 5	F 550		

was not afraid, only that it startled her. She said MA #1 never flicked her before or after that one time, but still, she should have not done it. The resident wasn't annoyed or fearful in any way.

An interview was conducted by phone on 07/10/24 at 2:30 PM with MA #1. She said on 04/10/24 around 10:00 PM, she went into Resident #19's room to check on the two nursing aides (NA #4 and NA #5) and ask them if they needed any assistance cleaning up Resident #19. She said when she peered into the resident's room, she saw that the resident was wandering in her room, a normal behavior for her, and had smeared feces all over herself and the room. She said she then entered the resident's room with additional towels and helped the two aides clean up the resident and her room. MA #1 said at one point the resident was becoming fidgety and tried to touch everything she could with her soiled hands, as she was trying to steer resident's feces covered hands away from her face, hair, and everything else. MA #1 said she had to flick the excess feces off her own gloves, while at the same time keeping the resident from contaminating more areas. The MA said she had to push Resident #19's own soiled hand away to keep it from smearing on the resident's face and her (MA #1's) face. The MA stated she did not flick the resident and was not rough with the resident in any way. She said that the flicking motion of her hand was to get the excess feces off her gloves, and being in such a mess, she just made a joke. The MA said after they were done cleaning the resident and her room, they wheeled the resident to the nursing station and gave her a goldfish snack, which the resident thanked her for. The MA said the resident was never upset and did not complain of anything to her, nurses,

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F 550	Continued From page 6 or aides. An interview was conducted on 7/10/24 at 4:30 PM with the Administrator. The Administrator said when he interviewed MA #1 on the phone, she told him that she flicked the resident's forehead on 04/10/24 around 10:30 PM. The administrator said facility staff should never flick a resident, even if it is in fun, and is never appropriate to touch a resident in that manner. An interview was conducted on 07/10/24 at 4:35 PM with the Director of Nursing. The DON said MA #1 denied flicking the resident's forehead with her middle finger.	F 550		
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	F 584		8/21/24

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F 584	Continued From page 7 services necessary to maintain a sanitary, orderly, and comfortable interior; §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 observations and staff interviews the facility failed to remove the black greenish substance from the commode base caulking in resident rooms (204, 207, 302, 310, 703, 704, 705, 706, 708, 710, 712), and failed to replace broken or missing bathroom door threshold strips in resident rooms (312, 310, 710), These failures occurred on 3 of 5 hallways (200, 300, and 700 halls) observed for a safe, clean, homelike environment. Findings included: An observation on 07/09/24 at 9:25 AM revealed resident room #704 commode with black greenish substance located around the base of the commode on the white caulk with a foul	F 584	The commode base caulking was replaced for room 204, 207, 302, 310, 703, 704, 705, 706, 708, 710 and 712 by the maintenance director on 8/6/2024. The bathroom threshold strips in rooms 312, 310 and 710 were replaced by the maintenance director on 8/6/2024. The administrator will conduct a facility inspection of all bathrooms 8/6/2024 to identify any additional commode base caulking issues and missing broken bathroom door threshold strips. All resident toilets were re-caulked. Thresholds found to be affected from the inspection were 312,310 and 710. Any additional areas identified will be corrected by the maintenance director by	

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F 584	Continued From page 8 sewage odor. An interview was conducted on 07/09/24 at 9:30 AM with Housekeeper #1. She said she was scheduled to clean all the rooms in the 700-hall, which included sweeping out and mopping the rooms. She said it was maintenance responsibility to re-caulk commodes. She agreed the black greenish substance located around the base of the commodes smelled and needed to be replaced by maintenance. She said she did not report commode caulking being black with odor to maintenance, because she thought maintenance was already aware of the issue. A tour of the facility was conducted on 07/09/24 at 12:35 PM revealed 10 resident commodes (204, 207, 302, 310, 703, 705, 706, 708, 710, 712), were noted to have black greenish substance located around the base of 8 of the 10 commodes, with 2 of 10 commodes not having any visible caulking at all, and 3 resident bathroom floors had broken or missing floor threshold strips in resident rooms (312, 310, 710) a potentially tripping or cutting the feet of residents stepping on the jagged edges. An interview was conducted on 07/09/24 at 1:15 PM with the Maintenance Assistant. He said he checked all bathrooms daily for any maintenance concerns and housekeepers cleaned residents' rooms and bathrooms daily. He said if housekeeping found maintenance issues it was their responsibility to write the concern down in one of the two maintenance work order books kept at the nursing stations, which he reviewed daily. He said the black greenish substance located around the base of the commode and on the caulk of the commodes with strong odor was	F 584	8/19/2024. The administrator educated the maintenance director on 8/6/2024 on weekly environmental inspections of the facility to identify any environmental concerns as part of the preventative maintenance of the facility. The Administrator will educate all staff on completing work orders and identifying environmental concerns by 8/16/2024. The administrator will audit 10 bathrooms a week to ensure there are no black greenish substance from the commode base caulking or bathroom door thresholds that need to be replaced. The audits will be completed for 12 weeks and reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The plan of correction may be altered, or audits extended to ensure ongoing compliance.	

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F 584	Continued From page 9	F 584		

okay, because the commodes didn't leak. However, he did agree that the commodes with missing caulking needed replacing to keep from leaking.

An interview was conducted on 07/09/24 at 2:00 PM with the Maintenance Director. The Maintenance Director observed 6 of the resident commodes with black greenish substance located around the base of the commodes on the caulk or on the porcelain? and stated he did not know what the black substance was around the base of the commode on the caulk/porcelain, there was a sewage odor coming off the blackened caulking, the caulking needed to be replaced, and the broken or missing floor thresholds needed to be replaced. The Maintenance Director said housekeeping and nursing aides were responsible to report those kinds of repairs by placing them in their work order books. He stated he could not provide documentation of completed or pending work orders that still needed to be addressed.

An interview was conducted on 07/09/24 at 2:15 PM with the Housekeeping Supervisor (HS). He stated he was not aware of the black greenish substance around the base of the resident's commodes on the caulk. He said housekeeping staff were responsible for checking toilets daily for leaking or needing repair, and he was not sure why any of those areas had a black greenish substance on them or why there was foul odor. The Supervisor said he did not have a daily floor cleaning schedule, or a deep clean schedule, and could not provide documentation to verify which of the residents' rooms and bathrooms were visually checked daily by him to ensure all rooms were cleaned by the housekeeping staff.

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F 584	Continued From page 10 A follow-up tour was conducted on 07/10/24 at 10:15 AM with the Administrator. The tour included observations of 6 resident commodes (207, 703, 705, 708, 710, 712). The observations revealed the commodes were noted to have black greenish substance located around the base of the commodes on the caulk and 3 resident bathroom floors had broken or missing threshold strips at the doorway in resident rooms (312, 310, 710). He expected all facility commode caulking to have been free of this black greenish substance and missing or broken bathroom thresholds to be replaced	F 584		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Pharmacy Manager, Consultant Pharmacist, Nurse Practitioner, and the Medical Director's interviews the facility failed to protect resident's right to be free from misappropriation of a narcotic pain medication (Hydrocodone-Acetaminophen oral tablet 5-325 milligrams) which resulted in a total of 60 missing tablets. This occurred for 2 of 2 residents (Resident #20, and Resident #61) who were reviewed for misappropriation of medications.	F 602	Resident #20 and Resident #61 were assessed by the unit manager for signs or symptoms of uncontrolled pain on 5/15/2024. On 5/15/2024 the Director of Nursing or designee interviewed all alert and oriented residents that had ordered for narcotic pain medication to ensure there were no issues when they asked for PRN pain medications and that their pain was being	8/21/24

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F 602	Continued From page 11 Findings included. 1.) Resident #20 was readmitted to the facility on 10/23/23 with diagnoses including fractured femur and sacrum. A physicians order dated 10/23/23 for Resident #20 revealed Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain. The Minimum Data Set (MDS) quarterly assessment dated 05/03/24 revealed Resident #20 was severely cognitively impaired. She had no complaints of pain and received opioids. She had no rejection of care. A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was filled on 05/03/24 for Resident #20 and received in the facility on 05/03/24 at 4:58 PM. The delivery was signed as received by Nurse #6. There was no record of the controlled substance declining count sheet for the 30 tablets of Hydrocodone-Acetaminophen 5-325 milligrams (mg) for Resident #20 that was delivered to the facility on 05/03/24. A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was filled on 05/10/24 for Resident #20 and received in the facility on 05/10/24 at 5:45 PM. The delivery was signed as received by Nurse #5.	F 602	managed. No issues were identified. On 5/15/2024 the Director of Nursing or designee assessed all cognitively impaired residents that had orders for narcotic pain medication for signs of uncontrolled pain with no issues identified. On 5/15/2024 the Director of Nursing or designee reviewed each Declining Count sheet on every medication cart and compared it to the narcotic card to validate that the count was accurate. On 5/15/2024 the DON or designee began educating all nurses on utilizing the Shift Change Controlled Inventory Count sheets, ensuring PRN medications are documented in the Electronic Medical Record and that administrative nurses are the only staff to remove empty narcotic cards and declining count sheets from the narcotic drawer. Education was completed on 5/17/2024. The nurse that was involved with both occurrences of misappropriation was reported to the Board of Nursing by the Director of Nursing on (date). The DON/designee will audit 5 PRN medication administrations weekly for 12 weeks to ensure they are being documented accurately in the Electronic Medical Record. The Unit Managers will audit each Narcotic Delivery Ticket for 12 weeks to ensure the medication is accurately added to the medication cart and the DON/designee will review the Shift Change Controlled Inventory Count sheets 5x week for 12 weeks to ensure the unit managers or other designated	

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F 602	Continued From page 12 Review of the Medication Administration Record (MAR) dated May 2024 for Resident #20 revealed no documentation that Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was administered to Resident #20 from 05/03/24 through 05/10/24 when the 2nd shipment and delivery was received in the facility. The controlled substance declining count sheet for Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) for Resident #20 that was delivered on 05/10/24 was reviewed and currently on the medication cart. The facility investigation summary dated 05/14/24 revealed the floor nurse (Nurse #6) reported to Unit Manager #2 that there was a new medication card of narcotic pain medication for Resident #20. Nurse #5 asked why this was done because it was ordered earlier in the week. Nurse #5 voiced that she saw the full card of the narcotic medication that was sent from the pharmacy earlier in the week. There were no administrations of the medication documented in Resident #20's electronic medical record. The facility searched all of the medication carts and reviewed delivery tickets to ensure the medication was actually sent to the facility. They were unable to find one card (30 tablets) of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) for Resident #20 that was initially delivered on 05/03/24. There was no harm to Resident #20. Resident #20 had no signs or symptoms of unrelieved pain and had pain medication available. During a phone interview on 07/11/24 at 10:36	F 602	individual are the only nurses removing the empty narcotic cards and declining count sheets. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations monthly for 3 months.	

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AM Nurse #5 stated the missing Hydrocodone-Acetaminophen oral tablets 5-325 milligrams for Resident #20 was discovered in May 2024 when they transitioned to a new electronic medical record system. She and Unit Manager #2 were discussing ordering medications through the new electronic system. She stated while she was reviewing medications to be ordered it occurred to her that she had a few less narcotic medication cards on her cart. She counted the medication cart and realized Resident #20 had a narcotic medication card missing for Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg). She stated she immediately notified Unit Manager #2 and reported to her that she knew Resident #20 had a brand-new card ordered the prior week, but it was missing. She stated she reviewed the electronic medical record and saw that the medication order was still active. She stated the 30 tablets of Hydrocodone-Acetaminophen oral tablets 5-325 milligrams that was received on 05/03/24 was missing from the medication cart. She reported they checked all of the medication carts in the facility and never found the missing medications for Resident #20. She stated she was routinely assigned to Resident #20, and she rarely needed pain medication and she also received scheduled Tylenol. She had dementia but had no nonverbal signs of pain and no grimacing during that time. She reported an investigation was done and she received education during that time regarding reconciliation of narcotic medications. She stated a new process was implemented since then and the Unit Manger or Director of Nursing were the only staff allowed to remove narcotic medication cards from the medication carts.

Multiple attempts were made during the survey to

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contact Nurse #6 who signed off on the delivery of Hydrocodone- Acetaminophen oral tablets 5-325 milligrams (mg) 30 tablets on 05/03/24 for Resident #20. There was no response from Nurse #6 who was suspended from the facility indefinitely.

During a phone interview on 07/11/24 at 09:56 AM the Pharmacy Manager stated their records showed an order for Hydrocodone-Acetaminophen 5-325 mgs for Resident #20 was dispensed to the facility on 05/03/24 for a total of 30 tablets. She reported another refill was dispensed on 05/10/24 for a total of 30 tablets. She stated it was appropriate that the pharmacy refilled the order that was delivered on 05/10/24 for another 30 tablets of Hydrocodone-Acetaminophen 5-325 mgs because the order was written to administer every 6 hours as needed and if Resident #20 was taking the medication every 6 hours, then the medication would needed to be refilled. She stated their narcotic delivery process included the driver delivered narcotics in a separate bag from other medications, and the narcotics must be checked in by a nurse upon delivery. The nurse must verify the right medication and right quantity then sign the 2-part perforated delivery sheet. The facility kept a copy, and the driver kept a copy. She stated only narcotics were checked in upon delivery, and other medications were not. She stated upon delivery if there was any discrepancy they should not accept or sign the form and send the medications back with the driver. She stated no Hydrocodone-Acetaminophen 5-325 mg tablets were returned to the pharmacy for Resident #20.

During an interview on 07/11/24 at 10:30 AM Unit

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Manager #2 stated Nurse #5 made her aware of the discrepancy regarding Resident #20's Hydrocodone-Acetaminophen 5-325 mg tablets. She stated they immediately started an investigation which included checking all of the medication carts and counting the narcotics on each of the carts. She stated Nurse #6 who signed that she received the delivery of 30 tablets of Hydrocodone-Acetaminophen 5-325 mg on 05/03/24 reported that she did not recall the events on 05/03/24 and could not account for the medication delivery. She reported that Nurse #6 was suspended from the facility indefinitely. She stated the 30 missing tablets for Resident #20 were never found.

During an interview on 07/11/24 at 11:00 AM the Nurse Practitioner stated she was not aware of the medication discrepancy regarding Resident #20's Hydrocodone-Acetaminophen 5-325 mg tablets. She stated Resident #20 had severe dementia and she routinely evaluated her and there had been no indication or reports of unrelieved pain. She stated Resident #20 also received scheduled Tylenol daily.

During a phone interview on 07/11/24 at 12:12 PM the Consultant Pharmacist stated he was not aware of the missing Hydrocodone-Acetaminophen 5-325 mg tablets for Resident #20. He stated he didn't review declining count sheets every month, when he conducted his monthly medication regimen reviews. He stated he did perform random controlled medication audits at times but had not reviewed Resident #20's declining count sheets for the Hydrocodone-Acetaminophen 5-325 mg tablets.

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During a phone interview on 07/11/24 at 4:43 PM the Medical Director stated she was made aware of the medication diversion regarding Resident #20. She stated she was aware that Nurse #6 was suspended from the facility indefinitely. She stated there had been no reports that Resident #20 had experienced unrelieved pain.

Review of the nursing progress notes from 05/01/24 through 05/31/24 revealed no documentation of complaints of pain from Resident #20.

An observation was conducted on 07/08/24 at 12:30 PM of Resident #20. She was observed sitting up in her wheelchair in the hallway. She was severely cognitively impaired. There were no indicators of pain or discomfort observed.

During an interview on 07/11/24 at 5:30 PM the Director of Nursing (DON) stated when they discovered the Hydrocodone-Acetaminophen 5-325 mg tablets for Resident #20 were missing they immediately started a full investigation. She stated all of the medication carts were checked and the medication was never found. She stated Nurse #6 who signed off on the pharmacy delivery sheet that she received the medication on 05/03/24 was suspended indefinitely. She indicated that she interviewed Nurse #6, and she had no memory of 05/03/24 and didn't remember signing for the Hydrocodone-Acetaminophen 5-325 mg tablets on 05/03/24. When Nurse #6 was asked what prompted her to reorder Hydrocodone-Acetaminophen 5-325 mg on 05/08/24 that was delivered on 05/10/24 she reported Resident #20 was out of the medication at that time, so she gave Resident #20 Tylenol and reordered the medication. She indicated a

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plan of correction was initiated on 05/14/24 that included audits of controlled medications, in-service education on drug diversion, the chain of custody for controlled medications and medication rights. She reported audits of narcotic sheets were still ongoing and an ad hoc QAPI (Quality Performance and Improvement) meeting was held to discuss this issue on 05/17/24. She stated once the audits began, they found a medication discrepancy regarding Hydrocodone-Acetaminophen 5-325 mg tablets for another resident (Resident #61).

2.) Resident #61 was admitted to the facility on 03/26/24 with chronic pain and on Hospice services.

The Minimum Data Set (MDS) admission assessment dated 04/01/24 revealed Resident #61 was cognitively impaired. She had no complaints of pain and received opioids. She had no rejection of care.

A physicians order from Hospice dated 04/05/24 for Resident #61 revealed Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain.

A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was filled on 04/05/24 for Resident #61 and received in the facility on 04/05/24 at 11:58 PM. The delivery was signed as received by Nurse #17.

A summary of the facility investigation dated 05/14/24 revealed: during the initial investigation

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beginning on 05/14/24 regarding Resident #20, the facility found through educating staff that there was another questionable drug diversion regarding missing narcotic medication cards for Resident #61. On 05/15/24 Nurse #17 voiced concerns to the Director of Nursing and Unit Manager #2 regarding Resident #61's Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) tablets. She questioned the doses administered and stated she was the nurse that usually administered the medication and was concerned because she did not recall any direction changes, or any sent back to the pharmacy. The investigation revealed the following:

On 04/05/24 30 tablets of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams was sent to the facility. The order was called in by the Hospice physician.

On 04/05/24 at 11:58 PM Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was received in the facility. The delivery sheet was signed by Nurse #17.

On 04/05/24 through 04/18/24 a total of 10 doses of Hydrocodone-Acetaminophen oral tablets 5-325 milligrams were documented as administered on the electronic Medication Administration Record (MAR) to Resident #61. The facility was unable to locate the declining inventory sheet.

On 04/19/24 at 9:45 AM Nurse #6 faxed a new order to the pharmacy for Hydrocodone-Acetaminophen oral tablets 5-325 milligrams for 15 tablets for Resident #61.

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On 04/19/24 at 5:07 PM Nurse #6 signed off on the pharmacy delivery sheet that she received Hydrocodone-Acetaminophen oral tablets 5-325 milligrams for 15 tablets for Resident #61.

On 04/19/24 through 04/25/24 a total of 5 doses of Hydrocodone-Acetaminophen oral tablets 5-325 milligrams were documented as administered on the electronic Medication Administration Record (MAR) to Resident #61. The facility was unable to locate the declining inventory sheet.

On 04/26/24 at 7:05 AM Nurse #6 faxed a new order to the pharmacy for Hydrocodone-Acetaminophen oral tablets 5-325 milligrams for 30 tablets for Resident #61.

On 04/27/24 at 12:23 AM Nurse #18 signed the delivery sheet that she received 30 tablets of Hydrocodone-Acetaminophen oral tablets 5-325 milligrams for Resident #61. This medication remained on the medication cart.

On 05/17/24 the pharmacy confirmed no narcotic medications were returned to the pharmacy for Resident #61.

On 05/17/24 staff verified that Resident #61 had Hydrocodone-Acetaminophen oral tablets 5-325 milligrams available for administration. Staff reported no complaints of uncontrolled pain.

Attempts were made to contact Nurse #17 during the survey, there was no response.

Multiple attempts were made during the survey to contact Nurse #6, there was no response.

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During an observation on 07/10/24 at 10:30 AM Resident #61 was observed lying in bed. She was calm and in no distress. She could not engage in conversation. There were no signs or symptoms of pain observed.

During an interview on 07/11/24 at 11:30 AM Unit Manager #2 stated during the narcotic audits regarding Resident #20's missing narcotic medication a discrepancy was also found regarding Resident #61's Hydrocodone-Acetaminophen oral tablet 5-325 milligrams. She indicated Nurse #17 who signed off on the narcotic delivery sheet for Resident #61 on 04/05/24 voiced concerns to her during the audits regarding Resident #61's narcotic medication which prompted further review. She stated they discovered Resident #61 also had Hydrocodone-Acetaminophen oral tablets 5-325 milligrams that were unaccounted for. She indicated Resident #61 received from the pharmacy a total of 45 tablets of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams between 04/05/24 through 04/19/24 and only 15 doses were accounted for. She stated the declining inventory sheets were missing for the 45 tablets.

During a phone interview on 07/11/24 at 4:43 PM the Medical Director stated she was made aware of the medication diversion regarding Resident #61. She stated there had been no reports that Resident #61 had experienced unrelieved pain.

During an interview on 07/11/24 at 5:30 PM the Director of Nursing (DON) stated they discovered the Hydrocodone-Acetaminophen 5-325 mg tablets for Resident #61 were unaccounted for

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F 602	Continued From page 21 during audits regarding Resident #20. She stated Resident #61 was admitted on Hospice services. She stated a full investigation was conducted. She indicated that they could not account for 30 of the 45 tablets for Resident #61 that were received in the facility. During an interview on 07/11/24 at 5:30 PM the Administrator stated a full investigation was conducted regarding the missing Hydrocodone-Acetaminophen 5-325 mg tablets. He stated the State Agency, and the police were notified. He reported they had a high suspicion that Nurse #6 was involved, and she was suspended indefinitely. He stated they had not reported Nurse #6 to the Board of Nursing yet and were waiting on the police to come investigate. He stated they notified the police on 05/14/24 and had contacted them a few times since to follow up and they had yet to send an officer out to investigate.	F 602		
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 observation and staff interview, the facility failed to provide a safe environment in the 700-hall by scrubbing floors with a scrubber that had a broken squeegee attachment which	F 689	The Director of Housekeeping ensured any water that was identified and expressed to him during the survey was dried up. The squeegee attachment for	8/21/24

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F 689	Continued From page 22 prevented excess water from being removed from the floor, leaving puddles of water behind, and failed to post wet floor signs on the wet 700 hallway floor that was wet and puddled with water left by the scrubber while staff were present on (2) of (4) days of the survey. The findings include: A tour and observation of the facility was conducted on 07/08/24 at 12:10 PM of the 700-hall revealed multiple large puddles of water down the entire length of the hall, and no wet floor signs posted down the hall. A search of the hall revealed no floor technician could be found. An interview was conducted on 07/08/24 at 12:15 PM with Unit Manager #2. She said she worked all over the building as a nurse unit manager and did notice 700-hall had many water puddles on the floor with no wet floor signs posted. She said the hallway must have been scrubbed sometime that morning. She said the floor tech should have come back to the hall and mopped up the puddled water he left behind and posted wet floor signs until the floor was dry, which was not done. She stated the wet floor with no wet floor signs posted was a potential fall hazard. An interview and tour were conducted on 07/08/24 at 12:20 PM with the Director of Nursing (DON). She observed the 700-hall and employee service hall with many water puddles on the floor without wet floor signs posted. She stated the wet floor should have had wet floor signs posted while wet and was currently a slip hazard. She stated she would get housekeeping to mop up the puddled water and get someone to post yellow	F 689	the floor scrubber was replaced 7/12/2024. The administrator conducted a facility environmental inspection on 7/10/2024 to ensure any wet floors in the facility had a wet floor sign visible. There were no additional findings observed. The administrator will educate all staff on ensuring any water puddles are dried immediately and wet floor signs are present any time the floors are wet. The education will be completed by 8/18/2024. The administrator will conduct a facility environmental inspection 3x week for 12 weeks to ensure there are no wet floors without proper signage. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The QA committee may alter the plan of correction or extend the audits to ensure ongoing compliance.	

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wet floor signs down the halls.

An interview was conducted on 07/09/24 at 2:00 PM with the Maintenance Director. The Maintenance Director stated on Monday 07/08/24 he observed 3 large water puddles down the 700-hall left by the scrubber. He said the scrubber was worn out and the squeegee attached to it was broken and was not functioning properly. He said he asked for a new scrubber or the squeegee attachment to be fixed but was told it was not in the budget. He said the floor tech should have mopped up the excessive water on the 700-hall floor and posted wet floor signs.

An interview was conducted on 07/09/24 at 2:10 PM with the Housekeeping Supervisor. He said their scrubber was worn out, wasn't working as it should, and needed to be replaced.

An interview was conducted on 07/09/24 at 2:30 PM with the Floor Technician. He stated their floor squeegee was not working good and needed to be fixed.

An interview was conducted on 07/09/24 at 4:08 PM with Housekeeper #1 on the 700-hall. She said she just finished mopping the 700 hall and resident #703's room around 2:00 PM. She said she did not place wet floor signs along the 700-hall because the floor was dry. She said she did not know where the water on the floor near room 703 came from, stating her cart and mop don't leak, and that the water did not come from her.

An interview was conducted on 07/10/24 at 10:15 AM with the Administrator. He said the wet floors he observed on the 700-hall on 07/08/24 should

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F 689	Continued From page 24 have had wet floor signs posted and did not, being a fall hazard. He also said the wet floor observed on 07/09/24 by resident room # 703 went unnoticed by staff, which was the reason no wet floor signs were posted.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff, registered dietician (RD) and Nurse Practitioner interviews, the facility failed to 1). obtain and record accurate weights as ordered for 4 of 4 residents reviewed for weights (Resident #83, Resident #63, Resident #91, and Resident #29) and 2). failed to verify the accuracy of 2 residents with a	F 692	A weight was obtained for resident #83, resident #63, resident #91 and resident #29 on 8/07/2024. The weights were reported to the provider on 8/08/2024 with no new orders. The Director of Nursing or designee	8/21/24

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F 692	Continued From page 25 significant change in weight (Resident # 83 and Resident #63). Findings included: 1.Resident #83 was admitted on 2/8/24 with diagnosis which included in part: hepatitis without ascites, diabetes mellitus, and hypertension. Review of Resident #83's physician orders revealed a diuretic, a medication which helps the body get rid of extra fluid, was not ordered. Review of Resident #83's electronic health record revealed the following weights were recorded: 2/8/24 280.6 pounds (Lbs.). Review of Resident #83's care plan revealed a 2/9/24 focus of increased risk for poor nutrition status related to disease process cirrhosis of the liver. Interventions indicated to monitor weight per protocol. Review of Resident #83's physician orders revealed an order dated 2/12/24 to obtain weight on admission and then weekly for 4 weeks. Resident #83's admission Minimum Data Set (MDS) dated 2/15/24 indicated resident with severe cognitive impairment, weight of 281 pounds, no weight loss or gain, and received a therapeutic diet. Review of Resident #83's electronic health record revealed the following weights were recorded: 2/15/24 no weight recorded. 2/22/24 no weight recorded	F 692	obtained a weight on every resident in the facility on 8/08/2024 and reported the weights to the registered dietician. The Director of Nursing will educate all clinical staff by 8/18/2024 on following physician orders for weights and reported any significant changes in weight to the provider and the registered dietician. The Director of Nursing or designee will audit all weights 5x week to ensure weights are obtained per policy or the resident's specific weights orders. Any weight that is not obtained will be done as soon as it is identified, and reeducation will be done with the nurse. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The QA committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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2/26/24 277.0 Lbs.
3/4/24 287.1 Lbs.
3/12/24 292.6 Lbs.
4/1/24 254.8 Lbs.

An interdisciplinary team progress note dated 4/10/2024 indicated resident was reviewed regarding weight loss over 3 weeks, 1 month and 2 months. The note indicated the resident had changes in edema status but did not indicate this was the reason for the 37.8 Lbs. or 12.92 percent weight loss since admission.

A progress note written by the Registered Dietitian (RD) dated 4/12/2024 indicated Resident #83 was reviewed due to weight change with current body weight of 254.8 pounds. Resident #83 triggered significant weight loss over 3 weeks, 1 month and 2 months. Meal intake of a low concentrated sweet diet was recorded as 50-100% of meals. A 3/26/24 progress note indicated the resident had edema and the weight fluctuations were possibly related to edema status changes.

Review of Resident #83's electronic health record revealed the following weights were recorded:

4/30/24 226.6 Lbs.
5/1/2024 226.6 Lbs.
5/6/24 226.6 Lbs.
5/17/24 232.4 Lbs.

6/4/24 243.2 Lbs.

Review of a Nurse Practitioner Progress Note dated 6/19/24 indicated Resident #83 was assessed due to weight gain. Resident #83 reported increased appetite since increasing

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Prozac and stated he had been eating well and had no visible increased ascites or edema.

7/3/24 249.8 Lbs.

An interview was conducted with the RD on 7/10/24 at 11:00 AM. The RD indicated there were discrepancies with Resident #83's weight. The RD stated the weight changes documented are not accurate and that the documentation indicated he had big shifts in his weight. RD stated she expected if a resident had a significant weight loss a reweigh would be completed according to the weight policy however this was not done. Accurate weights are important to evaluate the nutritional status of the resident.

Interview with Unit Manager #1 on 7/10/24 at 1:10 PM revealed the Nursing Assistants (NAs) were responsible for obtaining the weights on new admissions. The nurses inform the NAs who needs to be weighed daily. The nurses enter the weights into the computer. If there is a big difference in the weight, the resident should be reweighed right away or if the RD requests a reweigh it should be obtained and recorded.

An interview was conducted with the Nurse Practitioner (NP) on 7/11/24 at 11:00 AM. NP stated there were problems with discrepancies in weights and significant changes. NP stated consistency with weights was necessary to evaluate Resident #83's medical condition. NP stated Resident #83 had diagnosis of ascites and accurate monitoring of weights was necessary. NP stated she expected to be notified of any weight changes of 3 pounds or greater. NP stated Resident #83's weights were not accurate. NP indicated consistency with weights is necessary.

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Resident #83 has had some weight changes, but these weights are not accurate. NP stated Resident #83 has not had these weight changes that are recorded.

An interview was conducted with Unit Manager #2 on 7/11/24 at 2:00 PM. Unit Manager #2 revealed there was a problem with the accuracy of weights. Unit Manager #2 reviewed the weights that were recorded for Resident #83 and stated there were discrepancies. Unit Manager #2 stated she did not know why he was not reweighed when he had weight changes of greater than 3 pounds per the facility weight policy. Unit Manager #2 indicated a new system was started last week for the weights and she was now responsible for reviewing the weights weekly and daily for all long-term care residents.

An interview was conducted with Nursing Assistant (NA) # 2 on 7/11/24 at 3:10 PM. NA #2 revealed since February 2024 she was responsible for obtaining the weights on all the long-term care residents and she entered them in the electronic health record. NA # 2 stated she was not able to see the previous weights in the computer to see if there was a weight change, but she kept a paper copy of the previous weights. NA #2 stated she was aware that she was to report weight changes of 3 pounds or greater to the nurse and that she was to reweigh the resident. NA #2 stated she did not recall there had been any changes in Resident #83's weights that needed to be reported or that required a reweigh.

2.Resident #63 was admitted on 6/12/24 with diagnosis which included diabetes.

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Review of Resident #63's electronic health record revealed a physician order dated 6/12/24 to obtain weights on admission and weekly for 4 weeks.

Review of Resident #63's electronic health record revealed the following weights were recorded:

6/12/24 no weight recorded
6/18/24 213.2 lbs.
6/25/24 219.6 lbs.
7/2/24 Weight: 222.3 lbs.

Admission Minimum Data Set assessment dated 6/18/24 indicated Resident #63 was cognitively intact and had a weight of 213 Lbs.

Interview with Unit Manager #1 on 7/10/24 at 1:10 PM revealed the Nursing Assistants (NAs) were responsible for obtaining weights for residents on the rehab hall on admission. Unit Manager #1 stated resident weights were to be obtained on the first day of admission to the facility and were to be entered into the computer. Unit Manager #1 stated Resident # 63 was admitted to the rehab hall, and she did not know why his weight was not obtained on admission. Unit Manager #1 stated she was the manager of the rehab hall. Unit Manager #1 further stated she did not check to be sure that admission weights were obtained on all residents.

An interview was conducted with the Director of Nursing (DON) on 7/11/24 at 4:00 PM. The DON stated she expected weights would be obtained upon admission per the weight policy. The DON stated it was important to obtain the weights as soon as possible after admission to have a baseline and weights were to be obtained weekly

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for 4 weeks after admission or as ordered by the physician.

3. Resident #91 was admitted 6/12/24 with diagnosis which included in part pulmonary embolism and diabetes.

Review of Resident #91's admission Minimum Data Set (MDS) dated 6/18/24 revealed resident had moderate cognitive impairment, a weight of 244 Lbs. and had no weight loss or gain

The following weights were recorded in Resident #91's electronic health record:

6/12/24 no weight recorded
6/18/24 243.8 pounds (Lbs.)
6/25/24 197.2 Lbs.
6/27/24 333.8 Lbs.
7/2/24 335.7 Lbs.
7/5/24 311.6 Lbs.

An interview was conducted with the registered dietitian (RD) on 7/10/24 at 11:00 AM. The RD indicated there were obvious discrepancies in Resident #91's weights. The RD stated inaccurate weights provide an inaccurate reflection of the weight history and complicate her ability to evaluate the resident's nutritional status. The RD indicated when a resident had specific a medical diagnosis accurate weights were important for monitoring. The RD stated the weights recorded on 6/18/24 and 6/25/24 are obviously inaccurate. The RD indicated the weight was not obtained on admission and then the subsequent weights were inaccurate so that makes it harder to evaluate.

An interview was conducted with Unit Manager #1

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on 7/10/24 at 1:10 PM. Unit Manager #1 revealed the Nursing Assistants (NAs) were to weigh the residents on the rehab hall on the day of admission. Unit Manager #1 stated if there is a big difference in the weight, the resident should be reweighed, and weights should be obtained as soon as possible after admission. Unit Manager #1 indicated Resident # 91 was admitted to the rehab hall and she did not know why he was not weighed on admission. Unit Manager #1 stated she was the manager of the rehab hall and she did not check to ensure admission weights were obtained.

An interview was conducted with Nurse Practitioner (NP) on 7/11/24 at 11:00 AM. NP revealed there had been discrepancies with weights for a while. NP stated weights were needed as soon as possible after admission for establishing a baseline, for monitoring and dosing of medications. NP stated Resident #91 received diuretics, she had been adjusting his medications and it was difficult to evaluate fluid volume status without accurate weights. NP stated there were discrepancies in Resident #91's weights and accurate weights were important for monitoring.

An interview was conducted with the Director of Nursing (DON) on 7/11/24 at 4:00 PM. The DON stated she expected weights would be obtained upon admission per the weight policy. The DON stated it was important to obtain the weights as soon as possible after admission to have a baseline and weights were to be obtained weekly for 4 weeks after admission or as ordered by the physician. The DON stated weights were to be accurate. The DON indicated there was a problem with obtaining weights on admission and a system was needed to correct this.

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4. Resident #29 was admitted on 6/4/24 with diagnosis which included congestive heart failure with exacerbation.

Review of Resident #29's electronic health record revealed a physician order dated 6/4/24 for furosemide 40 milligrams (mg) twice per day. The order was discontinued on 6/24/24.

Review of Resident #29's electronic health record revealed a physician order dated 6/6/24 for daily weights.

Review of Resident #29's electronic health record revealed the following weights were recorded:

6/4/24 no weight recorded
6/5/24 no weight recorded
6/6/24 no weight recorded
6/7/24 no weight recorded
6/8/24 no weight recorded
6/11/24 117.2 lbs.
6/12/24 117.5 lbs.
6/13/24 118.2 lbs.
6/14/24 118 lbs.
6/15/24 116.8 lbs.
6/16/24 118.6 lbs.
6/18/24 117.4 lbs.
6/19/24 121 lbs.
6/20/24 120.4 lbs.
6/21/24 120.0 lbs.
6/22/24 122 lbs.
6/23/24 no weight recorded
6/24/24 no weight recorded

Review of Resident #29's electronic health record revealed a physician order dated 6/24/24 for

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furosemide 80 mg twice per day. Order was discontinued on 6/28/24.

Review of Resident #29's electronic health record revealed the following weights were recorded:

6/25/24 118.4 lbs.
6/26/24 120.8 lbs.
6/27/24 122.2 Lbs.
6/28/24 123.1 Lbs.

Review of Resident #29's electronic health record revealed a physician order dated 6/28/24 for furosemide 40 mg twice per day.

Review of Resident #29's electronic health record revealed the following weights were recorded:

6/29/24 123.6 Lbs.
6/30/24 125 Lbs.
7/1/24 123.8 Lbs.
7/2/24 120.9 Lbs.
7/3/24 no weight recorded
7/4/24 122 Lbs.
7/5/24 125 Lbs.

Review of Resident #29's electronic health record revealed a physician order dated 7/5/24 for furosemide 80 mg twice per day.

Review of Resident #29's electronic health record revealed the following weights were recorded:

7/6/24 no weight recorded
7/7/24 no weight recorded
7/8/24 130.4 Lbs.

An interview was conducted with the registered dietitian (RD) on 7/10/24 at 11:00 AM. The RD

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stated the admission weight, and the ordered daily weights were important to evaluate the resident's fluid and nutritional status. The RD indicated Resident #29 had congestive heart failure and weights were important for monitoring. The RD stated Resident #29's weight fluctuations were likely due to the medical condition and the adjustment of her diuretic medication but the ordered daily weights were essential.

An interview was conducted with Unit Manager #1 on 7/10/24 at 1:10 PM. Unit Manager #1 revealed the Nursing Assistants (NAs) were responsible for obtaining weights for the residents admitted to the rehab hall. The nurses informed the NAs which residents were to be weighed and then the nurses entered the weights into the computer. Unit Manager #1 stated weights should be obtained as soon as possible after admission and as ordered. Unit Manager #1 stated she was not aware of admission weights not being obtained or that daily weights had been missed.

An interview was conducted with Nurse Practitioner (NP) on 7/11/24 at 11:00 AM. NP revealed there had been discrepancies with weights for a while. NP stated weights were needed as soon as possible after admission for establishing a baseline, for monitoring and dosing of medications. NP stated Resident # 29 was medically complex and received high doses of diuretics. NP indicated she had been adjusting Resident #29's medications and it was difficult to evaluate fluid volume status without accurate weights. NP stated obtaining weights daily as ordered was important for monitoring Resident #29's condition.

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F 692	Continued From page 35 An interview was conducted with the Director of Nursing (DON) on 7/11/24 at 4:00 PM. The DON stated she expected weights would be obtained upon admission per the weight policy. The DON stated it was important to obtain the weights as soon as possible after admission to have a baseline and weights were to be obtained as ordered. The DON indicated a resident receiving a diuretic with an order for daily weights should be weighed as ordered and the provider should be notified of changes.	F 692		
F 693 SS=J	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		

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F 693	Continued From page 36	F 693	Past noncompliance: no plan of correction required.	

by:
Based on observation, record review, and staff, Nurse Practitioner and Physician interviews the facility failed to follow a physician order to hold a tube feeding (nutrition administered through a tube directly into the stomach) following an episode of vomiting for 1 of 1 resident (Resident #98) reviewed for tube feeding. The tube feeding that was ordered to be held was administered to Resident #98 on 1/24/24 through 1/25/24. The Nurse Practitioner observed the resident lying flat in bed, with the tube feeding running, vomit on his body, and respiratory distress symptoms that included elevated respirations, shortness of breath and decreased oxygen level. Resident #98 was hospitalized from 1/25/24 through 2/14/24 with a diagnosis of septic shock (widespread infection) secondary to aspiration pneumonitis (lung infection due to material from the stomach entering the lungs) and acute hypoxic respiratory failure (inadequate oxygen in the blood).

Findings included:

Resident #98 was admitted on 12/27/23 with diagnosis which included stroke, dysphagia (difficulty swallowing), feeding tube status, and diabetes.

Review of Resident #98's electronic health record revealed the following physician orders dated 12/27/23:

Pureed diet with nectar consistency liquids.
Tube feeding formula Fiber Source 240 milliliters (ml) via feeding tube every 4 hours.
Elevate the head of bed 30-45 degrees during feeding and for 30 minutes after, if tolerated.

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Review of Resident #98's care plan revealed a focus area dated 12/28/23 that resident required tube feeding for nutrition. The goal indicated Resident #98 would maintain adequate nutrition and hydration via tube feeding. Interventions included administer feeding and hydration via feeding tube as ordered, report to the provider abnormal breath sounds, nausea or vomiting and maintain the head of the bed elevated.

Review of Resident #98's admission Minimum Data Set (MDS) assessment dated 1/3/24 indicated resident was severely cognitively impaired, had a feeding tube and received 51% or more total calories via tube feeding during the entire 7 day look back period and his average fluid intake was 501 cubic centimeters (cc's) or more via tube feeding.

Review of a 1/4/24 Speech Therapy evaluation indicated Resident #98 had severe dysphagia and increased risk of aspiration. Resident #98 also had impaired cognition with impaired expressive language and communication skills.

Review of Resident #98's electronic health record revealed the following physician orders dated 1/5/24:
" if resident did not consume 50 percent of meals, then administer a bolus, an intermittent method of delivering tube feeding, of tube feeding formula Fiber Source 240 ml daily three times per day.
" Discontinue Fiber Source 240 ml via feeding tube every 4 hours.

Review of a weight note by the Registered Dietitian (RD) dated 1/17/24 revealed Resident

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#98 was reviewed for significant weight loss. The note indicated Resident #98 received a regular pureed diet with nectar thick liquids and Fiber Source 240 ml after meals if less than 50 percent consumed. RD recommended nocturnal tube feeding at 60 ml per hour for 10 hours daily with water flushes of 150 ml before and after tube feeding due to continued poor intake and weight loss.

Review of Resident #98's electronic health record revealed a physician order dated 1/17/24 for tube feeding formula Fiber Source at 60 milliliters (ml) per hour for 10 hours nightly from 8:00 PM to 6:00 AM. Flush the feeding tube with 150 ml of water at tube feeding initiation nightly and when the feeding is taken down in the morning.

A nursing progress note written by Nurse Manager #1 dated 1/24/24 at 2:42 PM indicated Resident #98 had a poor appetite. Resident #98 had an order for mechanically altered diet with thickened liquids and received tube feedings nightly and as needed following meals if intake was less than 50 percent. Resident #98 had a change in condition. Nurse Manager #1 stated in the progress note that following the lunch meal she administered the ordered bolus tube feeding due to poor intake less than 50 percent at the meal. Following administration of the bolus tube feeding, Resident #98 vomited. The provider and family were notified.

Review of Resident #98's electronic health record revealed a physician order dated 1/24/24 at 5:50 PM entered by Unit Manager #1 from Nurse Practitioner (NP)#3. The order stated hold tube feeding due to emesis (vomiting) and tube feeding intolerance. The order did not specify the

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bolus or continuous feeding or both.

A nursing progress note written by Unit Manager #1 dated 1/24/24 at 5:58 PM indicated Resident #98 experienced a second episode of vomiting and NP #3 was notified. A new physician order was received to hold the ordered tube feeding.

An in-person interview was conducted with Unit Manager #1 on 7/10/24 at 3:10 PM. Unit Manager #1 stated she was assigned to Resident #98 on 1/24/24 from 7:00 AM to 3:00 PM. Unit Manager #1 stated on 1/24/24 Resident #98 had episodes of emesis and she reported this to NP #3. Unit Manager #1 stated NP #3 gave an order to hold Resident #98's tube feeding on 1/24/24. Unit Manager #1 stated she did not put the order in the computer correctly and explained that she did not put a notation on the electronic Medication Administration Record (MAR) that the tube feeding was to be held. Unit Manager #1 stated because she did not enter the order onto the MAR correctly, the nurse would not have known to hold the feeding. Unit Manager #1 stated Resident #98 was sent out on 1/25/24 with vomiting and respiratory distress before she arrived for work that day. Unit Manager #1 stated after Resident #98 was sent to the hospital, she was reeducated regarding entering orders and placing orders on hold as well as reprimanded for the error she made. Unit Manager #1 stated in services were conducted with all nurses regarding carrying out physician orders and how to place an order on hold.

A progress note written by NP #3 on 1/24/24 at 6:08 PM revealed the NP was notified of the emesis episode. NP #3 indicated Resident #98 was seen sitting up in a wheelchair and appeared

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very fatigued and slumped over in the wheelchair. NP #3 helped the nursing assistant to safely transfer the resident back to bed. Resident #98 was boosted up in the bed and shook his head side to side indicating no when asked if he would like his head of bed elevated. Order was written to hold tube feedings.

Review of Resident #98's electronic Medication Administration Record (MAR) revealed the order to hold the tube feeding due to emesis did not appear on the MAR and the tube feeding orders remained in place, active and were not designated as on hold. The MAR indicated the tube feeding was electronically signed by Nurse #15 as administered at 8:00 PM on 1/24/24. The MAR indicated the tube feeding was electronically signed by Nurse #15 as completed at 6:00 AM on 1/25/24.

Review of a nursing progress note dated 1/25/24 at 8:35 AM written by Nurse #14 revealed upon start of shift, Resident #98 was observed with large amount of emesis of tube feeding from his nose and mouth. Resident #98 was coughing and struggling to expel emesis. Immediately the resident was placed in an upright sitting position in bed. Vital signs were obtained and were temperature 98.9, blood pressure 114/73, pulse 146 (above normal), oxygen saturation 85 percent (below normal of 95-100 percent) on room air. Resident was lethargic. NP #3 was notified of resident's condition. Oxygen was applied at 5 liters and a stat nebulizer treatment was administered. NP #3 arrived at the facility, assessed the resident and an order was received to send resident to the emergency room for evaluation.

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An interview via phone was conducted with Nurse #14 on 7/10/24 at 3:30 PM. Nurse #14 stated she worked at the facility through an agency for the past year. Nurse #14 stated she was assigned to Resident #98 on 1/25/24 for 7:00 AM to 7:00 PM shift. Nurse #14 stated she was a few minutes late for her shift that morning and the nurse from the prior shift (Nurse #15) had already left the facility. Nurse #14 stated she started making rounds on the residents right away. Nurse #14 stated she observed Resident #98 in bed with the tube feeding infusing. Resident #98 was coughing, struggling to breathe and had emesis pooled on him on the right side of the neck and right side of his body. Nurse #14 stated she sat the resident up higher in the bed, stopped the tube feeding, called NP #3 and received new orders. Nurse #14 stated NP #3 immediately responded and assessed Resident #98. Nurse #14 stated NP #3 instructed her to apply oxygen, give a nebulizer treatment and call 911. Nurse #14 stated NP #3 stated she could tell the Resident #98 aspirated. Nurse #14 stated the tube feeding was supposed to be held for Resident #98, but it was not.

Review of Resident #98's electronic health record revealed a progress note was written by NP #3 dated 1/25/24 at 8:45 AM. The note stated NP #3 received a call at 7:22 AM notifying of a change in Resident #98's condition. The note indicated Resident #98 was found with more emesis, a congested wet cough and oxygen saturations of 80% on room air (normal oxygen saturation is 95-100%). An order was given to initiate oxygen stat (immediately) at 5 liters via nasal cannula and administer a stat nebulizer treatment. The note stated NP #3 had emergently driven to the facility and entered the facility at 7:47 AM. Upon

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arrival, Resident #98 was observed with the nebulizer treatment in progress and was lethargic with an oxygen saturation of 90%. A verbal order was given to send Resident #98 to the emergency room and the NP remained with the resident at bedside until medics arrived at 8:15 AM. Assessment and plan indicated a diagnosis of aspiration with subsequent change in condition and oxygen desaturation with emergency room evaluation.

An interview was conducted via phone with NP #3 on 7/10/24 at 11:45 AM. NP #3 stated she no longer worked for the Medical Director. NP #3 indicated she frequently educated and reminded the nurses to keep Resident #98's head of the bed elevated 30-45 degrees to prevent aspiration. NP #3 stated Resident #98 was at increased risk for aspiration. NP #3 stated she arrived the morning of 1/25/24 early in the morning. NP #3 stated she entered Resident #98's room and observed him lying flat in bed with the tube feeding running and emesis on his body. NP #3 stated on 1/24/24 in the evening she entered the order in the computer system to hold the tube feeding and she informed Nurse #15 that the order was entered. NP # 3 stated the order was not carried out to hold the tube feeding and Resident #98 received the feeding all night. NP # 3 stated it was contraindicated to administer the tube feeding to a resident that was vomiting.

Resident #98 was transferred to the hospital on 1/25/24.

Review of Resident #98's emergency department encounter report dated 1/25/24 indicated resident presented with aspiration and bibasilar atelectasis (the lower parts of both lungs collapsed).

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Resident presented with tube feedings pouring out of his nose per EMS. Resident #98 was hypoxic (having low oxygen saturation) and hypotensive (having low blood pressure) on presentation to the Emergency Room and was also breathing at 50 breaths per minute. Resident #98's vital signs were blood pressure 86/61 (below normal), heart rate 118, temperature 100.7, respirations 46 (above normal). Resident #98 was treated with intravenous antibiotics and intravenous fluids.

Review of the hospital discharge summary dated 2/14/24 indicated Resident #98 was hospitalized from 1/25/24 through 2/14/24 with discharge diagnosis of septic shock secondary to aspiration pneumonitis and acute hypoxic respiratory failure. Resident #98 was discharged to another skilled nursing facility.

An interview via phone was conducted with Nurse #15 on 7/10/24 at 12:20 PM. Nurse #15 indicated she was an agency nurse that was assigned to Resident #98 on 1/24/24 on the 7:00 PM to 7:00 AM shift. Nurse #15 indicated she could not remember any specific information about Resident #98 and the NP order to hold the tube feeding on 1/24/24. Nurse #15 indicated she recalled being asked about an order for tube feeding for a resident but did not remember if it was part of an investigation regarding Resident #98. Nurse #15 indicated if the order was entered into the computer system correctly, it would have been designated on the electronic Medication Administration Record (MAR) as on hold. Nurse #15 indicated she utilized the electronic MAR to administer the tube feeding and medications. Nurse #15 stated the tube feeding order showed up on Resident #98's

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electronic MAR at 8:00 PM so she administered it. Nurse #15 did not recall if was reported to her by Unit Manager #1 or NP #3 to hold the tube feeding that night. Nurse #15 stated she did not recall if she turned off the tube feeding at 6:00 AM and did not recall Resident #98's condition when she left at the end of the shift.

An interview via phone was conducted with the Assistant Director of Nursing (ADON) on 7/11/24 at 10:30 AM. ADON stated she was working as the Assistant Director of Nursing in January 2024 but was no longer employed at the facility. ADON stated she recalled she had just come in to work the morning Resident #98 went to the hospital. ADON stated the nurse assigned to Resident #98 on 1/25/24 for the 7:00 AM to 7:00 PM shift was assessing Resident #98, and she went down to assist. ADON stated she observed Resident #98 had vomited tube feeding and she discovered later the tube feeding was supposed to have been on hold, but it was not held that previous night as ordered. ADON stated following this incident, she completed an incident report, an investigation and completed education/reeducation with all the nurses regarding placing orders on hold and ensuring all residents receiving tube feeding have the head of the bed elevated.

An interview via phone was conducted with the Physician on 7/11/24 at 10:45 AM. The Physician stated Resident #98 may have had aspiration pneumonitis. The Physician stated vomiting could likely have caused respiratory distress symptoms. The Physician stated the order should have been carried out to hold the tube feeding per the NP order. The Physician stated when a resident is vomiting, tube feeding should

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be held.

An in-person interview was conducted with the Regional Nurse Consultant on 7/11/24 at 1:30 PM. The Regional Nurse Consultant indicated the error was identified and the corrective action plan was initiated. The Regional Nurse Consultant stated the administrative nurses were educated regarding placing orders on hold and audits were completed 5 times per week for 6 weeks. The Regional Nurse Consultant stated the audits consisted of daily review of all new orders and the results were reviewed by the Quality Assurance committee. The Regional Nurse Consultant further stated all nursing staff were educated on elevating the head of the bed for all residents receiving tube feeding.

An in-person interview was conducted with the Director of Nursing (DON) on 7/11/24 at 4:00 PM. The DON stated she had just started at the time of the incident with Resident #98. The DON stated it was her expectation that orders would be followed as written and residents receiving tube feeding would have the head of the bed elevated. The DON stated the order to hold the tube feeding should have been entered onto the electronic Medication Administration Record and carried out. The DON further indicated she expected that if a resident was vomiting the tube feeding should have been held.

The Administrator was notified of immediate jeopardy on 7/11/24 at 5:15 PM.

The facility provided the following corrective action plan with a completion date of 2/16/24:

" Address how corrective action will be

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accomplished for those residents found to have been affected by the deficient practice:

On January 24, 2024, at 5:58 pm the Nurse Practitioner was notified that Resident #98 had episode of liquid vomitus, tan in color with no odor. The Nurse Practitioner ordered a diagnostic imaging for the Kidneys, Ureters and Bladder, a complete blood count, basic metabolic panel, Zofran 4 mg every 6 hours as needed for nausea and to hold tube feedings. The complete blood count and the basic metabolic panel were collected on January 24, 2024 at 9:00 pm. On January 25, 2024, at 7:22 am the Nurse Practitioner was notified for more emesis and congestion and oxygen saturation of 80% on room air. Telephone order was given by the Nurse Practitioner to start Resident #98 on 5 liters (L) of oxygen and to administer a breathing treatment. The Nurse Practitioner arrived at the facility on January 25, 2024 at 7:47 am and assessed Resident #98. The resident was lying flat with the tube feeding running when the NP arrived to assess the resident. Resident #98 appeared lethargic, heart rate was 118 and oxygen saturation 96% on 5L of oxygen. A verbal order was given to send the resident to the hospital. Resident left the facility with emergency medical transport at 8:15 am. Resident #98 did not return to our facility after the hospital transfer. The Assistant Director of Nursing reviewed the electronic medical record on January 25, 2024 and determined that the tube feeding order was never placed on hold and Resident #98 received enteral tube feeding from January 24, 2024 at 8:00 pm until January 25, 2024 at 6:00 AM. Root cause was discussed by the Interdisciplinary team, which included the Director of Nursing, Assistant Director of Nursing, Unit Manager #1,

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F 693	Continued From page 47 Unit Manager #2, the Wound Care Nurse and the Administrator on February 1, 2024 and it was determined that an additional order to hold the tube feeding was entered into the Electronic Medical Record but the actual tube feeding order was not placed on hold. This enabled the tube feeding order to remain active on the Medication Administration Record. The facility was unable to determine why the resident was lying flat during the tube feeding administration but the risk of aspiration for tube feeding residents was discussed. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 1, 2024, the Assistant Director of Nursing reviewed the electronic medical records for all other residents that had received enteral feeding since January 25, 2024 to ensure the tube feeding orders were correct and there were no missed hold orders and that each resident had an order to maintain the head of the bed at 30-40 degrees during feeding and for 30 minutes after, if tolerated. There were two additional residents receiving enteral feeding during the time frame but there were no hold orders identified and both residents had orders to maintain a 30-40-degree angle. The Assistant Director of Nursing assessed both like residents on February 1, 2024, and determined that lung sounds were clear for one resident, but the second resident had wheezing. The resident with wheezing was being treated for influenza and had breathing treatments ordered. A progress note was documented in each electronic medical record by the Assistant Director of Nursing on February 1, 2024.	F 693		

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" Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Assistant Director of Nursing provided education to the nurses on appropriately placing an order on hold instead of entering an additional hold order on February 5, 2024. The nurse who failed to enter the order correctly received one on one education on appropriately placing an order on hold instead of entering an additional hold order by the Assistant Director of Nursing on February 5, 2024. Unit Managers, the Wound Care Nurse and the Minimum Data Nurse were educated during the Interdisciplinary Team meeting by the Assistant Director of Nursing on February 1, 2024. The Assistant Director of Nursing contacted all nurses and certified nursing assistants on February 15, 2024, and provided education on ensuring residents with enteral tube feeding are kept at a 30-40-degree angle when in bed. 100% education was completed on February 15, 2024, via telephone.

" Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Director of Nursing or designee will review all new orders 5 times per week for 6 weeks to ensure any orders to hold tube feedings, medications or treatments were applied to the actual tube feeding, medication or treatment order instead of only entering an additional hold order. Weekend orders will be reviewed on Monday during the Clinical Morning Meeting. The facility determined the need to take the plan of correction to the Quality Assurance Performance

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F 693	Continued From page 49 Improvement Committee on February 1, 2024. A meeting was held on February 16, 2024 with the Medical Director and the Quality Assurance Performance Improvement committee to review the plan of correction and the monitoring plan. The facility conducts concierge rounds 5 times a week for all residents. Residents with enteral feeding are assigned the Minimum Data Set nurse. The concierge document includes resident bed positioning and are discussed in the administrative meeting 5 times a week. There were no reports of residents lying flat in the bed while receiving enteral feeding. Alleged Immediate Jeopardy Removal and Compliance date: 2/16/24 The Corrective Action Plan was validated on 7/11/24. Interviews with the nursing staff, DON and Administrator revealed the facility had provided education and training regarding placing orders on hold and ensuring that residents receiving enteral feeding had the head of the bed elevated at a 30-40-degree angle when in bed. Review of the monitoring tools for audits that began on 2/5/24 revealed the tools were completed as outlined in the corrective action plan. No concerns with placing orders on hold in the electronic MAR were identified. Positioning of residents in bed were observed with no concerns identified regarding residents lying flat in bed while receiving enteral feeding. The facility's immediate jeopardy removal date and compliance date was verified as 2/16/24.	F 693		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

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F 755	Continued From page 50 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. §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 observations, record review, staff, Pharmacy Manager and the Consultant Pharmacist interviews the facility failed to maintain a system of records of receipt and disposition for a controlled drug (Hydrocodone-Acetaminophen 5-325 milligrams) to enable reconciliation, and to maintain drug records in	F 755	Past noncompliance: no plan of correction required.	

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order to account for controlled drugs. This occurred for 2 of 2 residents (Resident #20 and Resident #61) reviewed for medication administration.

Findings included.

1.) A physicians order dated 10/23/23 for Resident #20 revealed Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain.

A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was filled on 12/09/23 for Resident #20 and received in the facility on 12/09/23 at 10:09 PM. The delivery was signed as received by Nurse #16. There was no record of the controlled substance declining count sheet for the 30 tablets received on 12/09/23

Attempts were made to contact Nurse #16 during the survey. Nurse #16 was an agency nurse and no longer worked in the facility. There was no response.

Review of the Medication Administration Record (MAR) for Resident #20 dated December 2023 through April 2024 revealed 18 of the 30 tablets of Hydrocodone-Acetaminophen 5-325 milligrams (mg) that was received on 12/09/23 were administered on the following dates. There was no declining count sheet for the doses administered from 01/28/24 through 03/19/24.

12/06/23 at 10:07 AM
12/26/23 at 05:05 PM

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01/28/24 at 07:30 PM
02/03/24 at 12:17 AM
02/08/24 at 01:14 PM
02/15/24 at 05:22 PM
02/20/24 at 05:23 PM
02/24/24 at 09:30 PM
02/25/24 at 03:32 PM
02/25/24 at 10:35 PM
02/26/24 at 05:40 AM
02/28/24 at 09:20 PM
02/29/24 at 05:32 AM
03/05/24 at 09:05 AM
03/09/24 at 09:33 AM
03/10/24 at 09:16 AM
03/15/24 at 11:08 AM
03/19/24 at 02:01 PM

A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was filled on 05/03/24 for Resident #20 and received in the facility on 05/03/24 at 4:58 PM. The delivery was signed as received by Nurse #6. There was no record of the controlled substance declining count sheet for the 30 tablets of Hydrocodone-Acetaminophen 5-325 milligrams (mg) for Resident #20.

Multiple attempts were made during the survey to contact Nurse #6 who signed off on the delivery of Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg) 30 tablets on 05/03/24 for Resident #20. There was no response from Nurse #6 who was suspended from the facility indefinitely.

A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325

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milligrams (mg) 30 tablets was filled on 05/10/24 for Resident #20 and received in the facility on 05/010/24 at 5:45 PM. The delivery was signed as received by Nurse #5.

The controlled substance declining count sheet for Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) for Resident #20 that was delivered on 05/10/24 was reviewed and currently on the medication cart.

The facility investigation summary dated 05/14/24 revealed the facility identified they were missing declining narcotic count sheets and had no system in place to reconcile narcotic documents.

During a phone interview on 07/11/24 at 09:56 AM the Pharmacy Manager stated their records showed an initial order for Hydrocodone-Acetaminophen 5-325 mgs for Resident #20 was dispensed to the facility on 10/23/23 and a total of 20 tablets were dispensed. The 2nd refill was dispensed on 12/09/23 for a total of 30 tablets. The 3rd refill was dispensed on 05/03/24 for 30 tablets. The 4th refill was dispensed on 05/10/24 for 30 tablets. She stated a declining count sheet for the narcotics were delivered to the facility along with the medication.

During a phone interview on 07/11/24 at 10:36 AM Nurse #5 stated they discovered Resident #20 was missing 30 Hydrocodone-Acetaminophen 5-325 milligram (mg) tablets. She indicated when they were looking for the missing medications, they discovered they were also missing the declining count sheets for the medication that was delivered on 05/03/24. She stated the declining

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count sheets were kept in the narcotic count notebook on the medication cart. She reported when a controlled medication was removed from the inventory count it was signed out on the declining inventory sheet and the sheets were counted at each shift change. She indicated the declining count sheets for Resident #20 were never found.

During an interview on 07/11/24 at 11:00 AM Unit Manager #2 stated during the investigation regarding Resident #20's missing Hydrocodone-Acetaminophen 5-325 mgs it was discovered that they were also missing the declining inventory sheets for the medication delivery on 12/09/23, and on 05/03/4. She stated they had no way of reconciling the medications because the declining count sheets were missing.

During a phone interview on 07/11/24 at 12:12 PM the Consultant Pharmacist stated he was not aware of the missing Hydrocodone-Acetaminophen 5-325 mg tablets for Resident #20. He stated he didn't review declining count sheets every month, when he conducted his monthly medication regimen reviews. He stated he did perform random controlled medication audits at times but had not reviewed Resident #20's declining count sheets for the Hydrocodone-Acetaminophen 5-325 mg tablets. He indicated the declining count sheets were to be kept on the medication cart for reconciliation.

During an interview on 07/11/24 at 5:30 PM the Director of Nursing (DON) stated when they discovered the Hydrocodone-Acetaminophen 5-325 mg tablets for Resident #20 were missing they immediately started a full investigation. She

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stated all of the medication carts were checked and the medication was never found. She stated Nurse #6 who signed off on the pharmacy delivery sheet that she received the medication on 05/03/24 was suspended indefinitely. She indicated during the investigation they discovered the declining count sheets for the medication were also missing. She indicated a plan of correction was initiated on 05/14/24 that included audits of controlled medications, and declining count sheets, in- service education on drug diversion, the chain of custody for controlled medications and medication rights. She reported audits of narcotic sheets were still ongoing and an ad hoc QAPI (Quality Performance and Improvement) meeting was held to discuss this issue on 05/17/24. She stated once the audits began, they found a medication discrepancy regarding Hydrocodone-Acetaminophen 5-325 mg tablets for another resident (Resident #61). She stated the declining count sheets for Resident #61's narcotic medication was also missing.

2.) A physicians order from Hospice dated 04/05/24 for Resident #61 revealed Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain.

A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 30 tablets was filled on 04/05/24 for Resident #61 and received in the facility on 04/05/24 at 11:58 PM. The delivery was signed as received by Nurse #17. The facility was unable to locate the declining inventory sheet.

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Attempts were made to contact Nurse #17 during the survey, there was no response.

A medication proof of delivery and shipment summary from the pharmacy revealed a delivery of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) 15 tablets was filled on 04/19/24 for Resident #61 and received in the facility on 04/19/24 at 5:07 PM. The delivery was signed as received by Nurse #6. The facility was unable to locate the declining inventory sheet.

Review of the Medication Administration Record (MAR) dated April 2024 revealed a total of 15 of the 45 doses of Hydrocodone-Acetaminophen oral tablets 5-325 milligrams were documented as administered to Resident #61.

During an interview on 07/11/24 at 5:30 PM the Director of Nursing (DON) stated they discovered the Hydrocodone-Acetaminophen 5-325 mg tablets along with the declining count sheets for Resident #61 were unaccounted for during audits regarding Resident #20. She stated Resident #61 was admitted on Hospice services.

The Corrective Action Plan initiated on 05/14/24 included:

On 05/14/24 the facility identified they were missing declining narcotic count sheets and had no system in place to reconcile narcotic documents.

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

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F 755	Continued From page 57 On 5/14/2024 the DON/Designee sorted and organized all narcotic count sheets and delivery tickets since 01/01/24 for reconciliation. 2.) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/14/2024 the Director of Nursing or designee reviewed each declining count sheet on every medication cart and compared it to the narcotic card to validate that the count was accurate. On 5/14/2024 the Director of Nursing or designee reviewed the shift change controlled inventory count sheets for accuracy. There were inconsistencies identified. 3.) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 05/14/24 the Regional Director of Clinical Services educated the Unit Managers and the DON on managing narcotic documents and on ensuring the empty cards and declining sheets were only removed by nursing administration. All nurses were educated by the DON/designee on utilizing the shift change controlled inventory count sheets, ensuring as needed medications were documented in the electronic medical record and that administrative nurses were the only staff to remove empty narcotic cards and declining count sheets from the narcotic drawer. Education was completed on 5/17/2024. 4.) Indicate how the facility plans to monitor its	F 755		

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F 755	Continued From page 58 performance to make sure that solutions are sustained; The DON/Unit Managers will audit each narcotic delivery ticket for 8 weeks to ensure the medication was accurately added to the medication cart. In addition, the DON/designee will review the shift change controlled inventory count sheets 5x a week for 8 weeks to ensure the Unit Managers were the only nurses removing the empty narcotic cards and declining count sheets. The DON will review the narcotic documents weekly to ensure they were being maintained appropriately. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations as needed. An ADHOC QAPI meeting was held on 05/17/24. 5.) Include dates when the corrective action will be completed. The facility alleged compliance with the corrective action plan on 05/18/24. Validation of the corrective action was completed on 07/11/24. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. The initial audits were verified, and audits were still ongoing. There were no concerns identified. The corrective action plan completion date was verified as 05/18/24.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		8/21/24

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F 761	Continued From page 59 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to record an opened date on two insulin pens that had shortened expiration dates. This was observed on 1 of 3 medication carts (200/300 hall medication cart) reviewed for medication storage. Findings included. Review of the manufacturer's instructions for Lantus insulin pens revealed to discard 28 days after opening. Review of the manufacturer's instructions for	F 761	The undated insulin pens were discarded by the Director of Nursing on 7/10/2024. The Director of Nursing or designee will inspect each medication cart by 8/07/2024 to ensure there are no undated open insulin pens on the carts. Any undated open insulin pens will be discarded and the facility will purchase new insulin pens for the residents. The Director of Nursing will educate all nurses by 8/18/2024 on medication storage using the Omnicare medication	

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F 761	Continued From page 60 Novolog insulin pens revealed to discard 28 days after opening. An observation of the 200/300-hall medication cart on 07/10/24 at 10:30 AM along with Nurse #7 revealed one Lantus insulin pen and one Novolog insulin pen stored on the medication cart that had been used with no opened dates labeled on the insulin pens. . During an interview on 07/10/24 at 10:35 AM Nurse #7 stated she was not aware the insulin pens were not dated and indicated she did not administer either of the two insulin pens to the residents today. She stated she typically was not assigned to the 200/300 hall medication cart but acknowledged the insulin pens were not dated with an opened date. She stated it was the responsibility of the nurse who initially opened the insulin pen to label it with an opened date so that it could be discarded after 28 days. During an interview on 07/10/24 at 2:00 PM the Director of Nursing stated insulin pens should be labeled with opened dates when they were initially opened. She stated education would be provided.	F 761	storage educational brochure. A copy of the handout will be placed on each medication cart for reference. The Director of Nursing or designee will audit all medication carts and medication refrigerators 5x week for 12 weeks to ensure there are no undated open insulin pens on the medication carts. Any undated open insulin pens will be discarded, and the facility will purchase new insulin pens for the residents. The audits will be reviewed by the quality assurance performance improvement committee monthly for 3 months. The QA committee may change the plan of correction or extend the audits to ensure ongoing compliance.	
F 770 SS=E	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.	F 770		8/21/24

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F 770	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and the Medical Director's interviews the facility failed to obtain a monthly complete blood cell count (CBC - a blood test that measures the number of red blood cells, white blood cells, and platelets in the blood) as ordered by the physician for a resident who received immunosuppressive drug therapy. This occurred for 1 of 1 resident (Resident #8) reviewed for laboratory services. Findings included. Resident #8 was admitted to the facility on 03/02/23 with diagnoses including rheumatoid arthritis and heart failure. A physicians order dated 11/27/23 for Resident #8 was in place to obtain a complete blood cell count (CBC), then obtain monthly CBC's for drug monitoring. Review of Resident #8's electronic medical record revealed a CBC was collected on 11/30/23 and reviewed by the physician. Further review of Resident #8's electronic medical record from 12/31/23 through 07/08/24 revealed no documentation or results of monthly CBC tests. The Minimum Data Set (MDS) annual assessment dated 05/05/24 revealed Resident #8 was cognitively intact and had no rejection of care. During an interview on 07/11/24 at 11:00 AM the Nurse Practitioner stated the Nurse Practitioner	F 770	The Director of Nursing notified the provider on 07/10/2024 that resident #8 did not have his labs collected as previously ordered. New lab orders were obtained. The Director of Nursing or designee reviewed the lab orders in the Electronic Medical Record on 08/18/2024 to ensure all lab orders had been entered correctly into the lab portal and that the labs and the results had been obtained. The MD will be notified of any missed lab testing. The Director of Nursing or designee will educate all nurses on entering lab orders in Matrix, entering lab orders in the lab portal and adding the lab to the lab book located on each nursing station by 08/18/2024. The Director of Nursing or designee will review all orders 5x week for 12 weeks to ensure all lab orders are added to the lab portal for collection in addition the lab books will be audited for 12 weeks to ensure labs are being collected per the physician order. The audits will be reviewed by the Quality Assurance Performance Improvement Committee for three months.	

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F 770	Continued From page 62	F 770		

who wrote the order for monthly CBC's no longer worked in the facility and she was not aware that there was an order in place for monthly CBC's for Resident #8. She reported she began working in this facility in January 2024 and conducted evaluations of Resident #8 routinely. She reported Resident #8 had complex medical issues and remained on immunosuppressive drug therapy and was followed by a Rheumatologist who also ordered laboratory work including CBC's and she could view the Rheumatology lab results through the hospital electronic medical record system. She indicated there was no concern at this time regarding Resident #8's CBC that was reviewed in the hospital electronic medical record and drawn on 06/21/24. She stated a CBC was ordered yesterday evening on 07/10/24 for Resident #8 when she was made aware of the order for monthly labs and the results were not available yet. She stated laboratory orders should be obtained according to the physician orders and she expected the lab results for all residents to be available for review promptly in the facility's electronic medical record to prevent occurrences of missing laboratory reports.

During an interview on 07/11/24 at 11:15 AM Unit Manager #1 stated she was the nurse who entered the initial order on 11/27/23 to draw monthly CBC's for Resident #8. She stated the order was entered correctly into the electronic medical record for the monthly CBC, but a requisition form was not put in the vendors notebook to notify the vendor to draw the lab. She stated once lab orders were entered into the electronic medical record the process included to fill out a requisition form and place it in the lab vendors notebook, then the vendor would come

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F 770	Continued From page 63 to the facility check the notebook and draw the lab. She stated that it appeared the requisition form was not placed in the notebook to draw the CBC's each month. She stated the facility recently transitioned to a new electronic medical record system and they had implemented a new process when labs were ordered. The new process included to enter the order into the electronic medical record then go directly to the vendors website and put the requisition in. She stated that not completing the requisition form and putting it in the lab notebook was done in error. During an interview on 07/11/24 at 3:30 PM the Medical Director stated typical CBC monitoring for immunosuppressive therapy was every 6 months, however she expected the lab orders to be followed and expected monthly CBC's to be drawn according to the order. She indicated Resident #8 had no outcome or change in condition from not obtaining a monthly CBC. During an interview on 07/12/24 at 4:00 PM the Director of Nursing stated they had made recent changes in how they ordered lab work. She reported the new process was that the nurse who entered lab orders would also enter the order into the vendors website. This process excluded having a nurse fill out a handwritten requisition form which expedited the process. She stated the nurses were educated on the new process. She indicated she was not aware that Resident #8 had an order for a monthly CBC and the original order for monthly CBC's should have been entered correctly. She stated labs should be drawn according to the physicians orders.	F 770		
F 842 SS=E	Resident Records - Identifiable Information	F 842		

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F 842	Continued From page 64 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, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 65 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, and staff interviews the facility failed to accurately document on the Medication Administration Record (MAR) the administration of a narcotic pain medication (Hydrocodone-Acetaminophen oral tablet 5-325 milligrams). This occurred for 1 of 1 resident (Resident #20) reviewed for medication administration. Findings included.	F 842	Past noncompliance: no plan of correction required.	

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A physicians order dated 10/23/23 for Resident #20 revealed Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain.

Review of the controlled substance declining count sheet for 30 tablets of Hydrocodone-Acetaminophen 5-325 milligrams (mg) for Resident #20 that was delivered to the facility on 10/23/23 revealed the medication was signed off on the declining count sheet for administration on the following dates:

10/24/23 at 10:00 PM
10/25/23 at 11:00 PM
10/26/23 at 10:00 PM
11/02/23 at 07:00 AM
11/23/23 at 10:00 PM
12/01/23 at 11:00 PM
12/10/23 at 09:00 PM
12/15/23 at 04:12 PM
12/16/23 at 09:40 AM

Review of the Medication Administration Record (MAR) for Resident #20 dated October 2023 through December 2023 revealed no documentation that Hydrocodone-Acetaminophen 5-325 milligrams (mg) was signed as administered on the following dates:

10/24/23 at 10:00 PM
10/25/23 at 11:00 PM
10/26/23 at 10:00 PM
11/02/23 at 07:00 AM
11/23/23 at 10:00 PM
12/01/23 at 11:00 PM
12/10/23 at 09:00 PM

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12/15/23 at 04:12 PM
12/16/23 at 09:40 AM

Attempts were made to contact Nurse #8 who signed out on the declining inventory count sheet Hydrocodone-Acetaminophen 5-325 milligrams (mg) to Resident #20 on 10/26/23 at 10:00 PM. The number was invalid.

During an interview on 07/11/24 at 2:00 PM the Director of Nursing (DON) stated Nurse #8 went out on leave and never returned to the facility.

Attempts were made during the survey to contact Nurse #19 who signed out on the declining inventory count sheet Hydrocodone-Acetaminophen 5-325 milligrams (mg) to Resident #20 on 10/24/23 at 10:00 PM, 10/25/23 at 11:00 PM, 11/02/23 at 7:00 AM, 11/30/23 at 10:00 PM., 12/01/23 11:00 PM, and 12/10/23 at 9:00 PM. There was no response.

During an interview on 07/11/24 at 2:00 PM the Director of Nursing (DON) stated Nurse #19 was an agency nurse and no longer worked in the facility

Multiple attempts were made during the survey to contact Nurse #6 who signed on the declining inventory count sheet Hydrocodone-Acetaminophen 5-325 milligrams (mg) to Resident #20 on 12/15/23 at 4:12 PM, and 12/16/23 at 09:40 AM. There was no response from Nurse #6 who was suspended from the facility indefinitely.

During an interview on 07/11/24 at 5:30 PM the Director of Nursing (DON) stated when they discovered the Hydrocodone-Acetaminophen

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5-325 mg tablets for Resident #20 were missing they immediately started a full investigation. She reported during the investigation they discovered that the Medication Administration Records were not accurate. She indicated a plan of correction was initiated on 05/14/24 that included audits of controlled medications, and declining count sheets, and Medication Administration Records. In- service education was provided on drug diversion, the chain of custody for controlled medications, medication rights, and documentation of as needed medications. She reported audits of narcotic sheets were still ongoing and an ad hoc QAPI (Quality Performance and Improvement) meeting was held to discuss this issue on 05/17/24.

The Corrective Action Plan initiated on 05/14/24 included:

On 05/14/24 the facility identified they were missing declining narcotic count sheets and had no system in place to reconcile narcotic documents.

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

On 5/14/2024 the DON/Designee sorted and organized all narcotic count sheets and delivery tickets and reviewed Medication Administration Records for reconciliation.

2.) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

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On 5/14/2024 the Director of Nursing or designee reviewed each declining count sheet on every medication cart and compared it to the narcotic card to validate that the count was accurate, and that the medication had been electronically signed off in the Medication Administration Record. There were inconsistencies identified.

On 5/14/2024 the Director of Nursing or designee reviewed the shift change controlled inventory count sheets for accuracy. There were inconsistencies identified.

3.) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 05/14/24 the Regional Director of Clinical Services educated the Unit Managers and the DON on managing narcotic documents and on ensuring the empty cards and declining sheets were only removed by nursing administration. All nurses were educated by the DON/designee on utilizing the shift change controlled inventory count sheets, ensuring as needed medications were documented in the electronic medical record and that administrative nurses were the only staff to remove empty narcotic cards and declining count sheets from the narcotic drawer. Education was completed on 5/17/2024.

4.) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The DON/Unit Managers will audit each narcotic delivery ticket for 8 weeks to ensure the medication was accurately added to the

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medication cart. In addition, the DON/designee will review the shift change controlled inventory count sheets 5x a week for 8 weeks to ensure the Unit Managers were the only nurses removing the empty narcotic cards and declining count sheets. The DON will review the narcotic documents weekly including the Medication Administration Records to ensure they were being maintained appropriately. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations as needed.

An ADHOC QAPI meeting was held on 05/17/24.

5.) Dates when the corrective action will be completed.

The facility alleged compliance with the corrective action plan on 05/18/24.

Validation of the corrective action was completed on 07/11/24. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. The initial audits were verified, and audits were still ongoing. There were no concerns identified. The corrective action plan completion date was verified as 05/18/24.