STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDAL PLACE KNIGHTDALE, NC 27545

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/26/24 through 8/30/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1B8S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 8/26/24 through 8/30/24. On 9/4/24 the survey team returned to the facility for additional information, therefore, the exit date was 9/4/24. Event ID#1B8S11. The following intakes were investigated NC00219530, NC00212920, NC00213864, NC00220665, NC00218738 and NC00213709. 3 of the 13 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.45 at tag F760 at a scope and severity J The tag F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/2/23 and was removed on 10/30/23. An extended survey was conducted.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		9/21/24

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

Electronically Signed | 09/17/2024

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

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F 604	Continued From page 1 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §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. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and responsible party (RP) interviews the facility failed to identify bolsters as a restraint, failed to assess the bolsters as a restraint, and utilized them without medical justification and without a physician order. This was for 1 of 1 resident (Resident #48)reviewed for restraints. Findings included: Resident #48 was admitted to the facility on	F 604	F604-Right to be Free from Physical Restraints: 1. On 08/28/24, The Nurse Manager removed the two bolster pillows for resident #48. The regional director of nursing educated the director of nursing on 08/28/24 on restraint use. The facility maintains a restraint free environment. 2. The Director of Nursing and or Nurse Managers conducted a quality review on all residents through personal observation	

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F 604	Continued From page 2 11/17/23 with a diagnosis of Alzheimer's disease and blindness. A review of the quarterly Minimum Data Set (MDS) dated 5/26/24 revealed Resident #48 was severely cognitively impaired, was totally dependent on staff for all activities of daily living and did not have restraints in place. A review of Resident #48's assessments revealed there was no restraint assessment completed. An observation of Resident #48 was conducted on 8/26/24 at 3:37 PM. She was lying in bed on her back with her knees pulled up to her chest. The resident was nonverbal. Two bolster pillows were observed, one on either side of her under the fitted sheet. They were cylindrical and were measured by her RP as three feet long by 8 inches in diameter. The residents bed was not against the wall, there were no side rails, and her bed was in the lowest position with fall mats on both sides. A second observation on Resident #48 was conducted on 08/27/24 at 12:40 PM. She was lying in bed on her right side with her legs pulled up with her knees pushing on the bolster. The RP was at the bedside. A third observation of Resident #48 on 8/27/24 at 2:10 PM revealed she was in bed with the bolsters in place and no one was in the room with her. Her bed was in the lowest position with bilateral fall mats in place. In an interview with Resident #48's family member, who was her RP, on 8/27/24 at 12:40 PM he stated he had brought the bolsters in	F 604	to ensure residents are free of restraints and the facility is maintaining a restraint free environment on 8/28/24. On 9/16/24, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Clinical Services and or Nursing Supervisor. 3. The Director of Nursing, Nurse manager and or Director of Staff Development nurse will educate licensed nurses and certified nursing assistance by 09/19/24 on restraint use and that all residents are to have the right to be free from physical or chemical restraints for discipline or convenience, and not required to treat the resident□s medical symptoms. The facility maintaining a restrain free environment. The Director of Nursing and or Nurse manager educated licensed nurses on reporting and documentation standards related to the use of restraints. Education will be completed by 09/19/24. Newly hired employees will receive education during orientation on restraint use and the facility will maintain a restraint free environment. 4. The Director of Nursing will report the results of the quality monitoring audits to the QAPI committee ensure compliance is achieved and maintained, monthly for three months and then quarterly for 2 quarters Findings will be reviewed by QAPI committee monthly and Quality monitoring will be updated as indicated. The Director of Nursing will conduct random Quality reviews of 5 resident□s a	

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F 604	Continued From page 3 about 4 or 5 months ago to keep the resident from falling out of bed as she could move around in bed on her own. He further stated he was using body pillows before that, and staff informed him he could not use them, so he brought the round bolsters instead. The RP indicated nursing staff were aware of the bolsters. He further stated the resident had not had a fall since he started using them. An interview with Nurse #1 on 8/27/24 at 12:52 PM revealed she was aware Resident #48 had bolster pillows on her bed and staff did not remove them. Nurse #1 stated she did not feel the bolsters were a restraint. She further stated the residents RP brought the bolsters in and placed them under the fitted sheet to keep the resident from falling out of bed. Nurse #1 revealed there was no order in Resident #48's record for bolsters to be used and her last fall out of bed was 3/30/24. In an interview with Nurse Aide (NA) #1 on 8/27/24 at 3:44 PM, she stated she was familiar with Resident #48. She further stated she was aware the Resident had bolsters on her bed to keep her from falling and NA#1 removed them after the RP left in the evening, usually after supper. NA #1 revealed she thought the resident was only to have the bolsters in place while her RP was visiting. She further revealed the resident was not able to roll herself over the bolsters that she had seen. In an interview with the Director of Rehabilitation (DOR) on 8/28/24 at 9:24 AM she revealed the Rehabilitation department did not do an assessment on Resident #48 regarding restraints or bolsters.	F 604	week x12 weeks to ensure the facility is providing the right to be free from physical or chemical restraints. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse and at least one direct care staff. Date of Compliance on 9/21/24.	

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F 604	Continued From page 4 An interview with the MDS Nurse on 8/27/24 at 4:01 PM revealed a restraint was defined as anything that prohibited maximum free movement of arms legs or body. She stated Resident #48 was not coded as having a restraint on the MDS. The MDS nurse further stated bolsters or pillows under the fitted sheet would likely be a restraint and would need to be removed. An interview and observation with the Director of Nursing (DON) was conducted on 8/27/24 at 2:15 PM. The DON stated she was unaware Resident #48 had bolsters on her bed. During an observation of the bed with DON, she stated she did not believe the bolsters to be a restraint. The DON further stated she believed the Resident would be able to push them out from under the sheet or get over them as she moves around in bed independently. The DON stated she had not observed Resident #48 in bed with the bolsters as she was unaware she had them. In an interview with the Administrator on 8/29/24 at 8:48 AM he stated he was unaware Resident #48 had bolsters on her bed and felt they were a restraint. He further stated that the resident had end stage Alzheimer's and would not understand that the bolsters were there or be able to remove them herself so they likely restricted movement. The Administrator indicated the resident should have been assessed for safe use of bolsters.	F 604		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		9/21/24

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F 637	Continued From page 5 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment following hospice election for 1 of 1 resident (Resident #78) reviewed for death and failed to complete a significant change in status Minimum Data Set (MDS) assessment for a resident who discharged from hospice services for 1 of 1 resident (Resident #48) reviewed for accidents. Findings included: 1. Resident #76 was admitted to the facility on 3/23/18. Her active diagnoses included chronic obstructive pulmonary disease, muscle weakness, and Alzheimer's disease. Review of Resident #76's hospice election form dated 5/29/24 revealed she was admitted to hospice on 5/29/24. Review of Resident #76's electronic health record revealed no significant change in status MDS assessment had been completed for Resident #76 following hospice election. During an interview on 8/27/24 at 2:17 PM the	F 637	F637-Comprehensive Assessment After Significant Change: 1. The Minimum Data Set (MDS) Coordinator assessed for need in significant change for resident #76 on 9/12/24. Resident #48 was reviewed by the MDS Coordinator on 9/12/24 for significant change when discharging from hospice services on 7/4/24. 2. The MDS Coordinator completed an audit of current residents to assess for significant change when there is a change in the residents health status that requires interdisciplinary review or revision to the care plan or both by 9/21/24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 09/16/2024 to formulate and approve a plan of correction for the deficient practice. 3. The MDS Coordinator was re-educated by the Executive Director on 9/16/24 to ensure the MDS Coordinator captures any significant change when the health status of the resident changes or they are discharged from hospice services per regulations.	

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F 637	Continued From page 6 Director of MDS Education stated a significant change in status MDS assessment was required following a resident's election of hospice. She stated Resident #76 should have had a significant change in status MDS assessment following her hospice election and did not know why it was not completed. She concluded the MDS Nurse was responsible, and she could have further information. During an interview on 8/27/24 at 3:05 PM the MDS Nurse stated a significant change in status MDS assessment is required following a resident's election of hospice. She concluded Resident #76 elected hospice on 5/29/24 and the significant change in status MDS assessment was missed. During an interview on 8/28/24 at 9:43 AM the Director of Nursing stated MDS assessments should be completed according to the Resident Assessment Instrument (RAI) manual's schedule. 2. Resident #48 was admitted to the facility on 11/17/23 with hospice services in place. A review of Resident #48's hospice discharge order revealed she was discharged from hospice on 7/4/24. A review of Resident #48's electronic health record revealed a significant change Minimum Data Set (MDS) was not completed within 14 days of discharge from hospice. In an interview with the MDS nurse on 08/29/24 at 1:47 PM she stated a significant change MDS would be completed if a resident were to be admitted to or discharged from hospice. She	F 637	4. The Director of Nursing will conduct random audits on 5 MDS assessments 3 times per week for 4 weeks, then weekly for 3 months, to ensure any health status change or discharge from hospice is captured as a significant change. The MDS Coordinator will report the results of the quality monitoring audits to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring audits will be updated as indicated. Date of Compliance on 9/21/24.	

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F 637	Continued From page 7 further stated she learned about significant changes in morning meeting every day and she was aware Resident #48 had been discharged from hospice. The MDS nurse revealed a significant change MDS should have been completed within 14 days of the resident's discharge from hospice. She was not sure how it was missed. An interview with the Director of Nursing (DON) was conducted on 8/29/24 at 2:15 PM. The DON stated a significant change MDS should have been completed for Resident #48 within 14 days of discharge from hospice. She was unaware it had not been completed. In an interview with the Administrator on 8/29/24 at 2:28 PM he stated he was unaware that a significant change MDS was not completed for Resident #48 when she was discharged from hospice. He further stated it should have been completed within 14 days of the discharge.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 1 of 5 residents (Resident #64) reviewed for unnecessary medications. Findings included:	F 641	F641 □ Accuracy of Assessments: Resident #64□s Minimum Data Set□s (MDS□) was corrected in the areas of antianxiety medications to accurately reflect the resident□s status on 8/29/24. A quality review was completed on the	9/21/24

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F 641	Continued From page 8 Resident #64 was admitted to the facility on 3/19/24 with a diagnosis of dementia. A review of Resident #64's admission Minimum Data Set (MDS) assessment dated 3/25/24 revealed she was moderately cognitively impaired. She was taking antianxiety medication and an indication was noted. A review of Resident #64's physician orders revealed an order dated 3/25/24 for clonazepam (an antianxiety medication) 0.5 milligrams give one tablet by mouth every 8 hours as needed for anxiety for 5 days. There were no other physician's orders for antianxiety medication for Resident #64 from 3/19/24 through 3/30/24. A review of Resident #64's March 2024 Medication Administration Record (MAR) revealed no documentation clonazepam 0.5 milligrams was administered to her. It further revealed no documentation that any other antianxiety medication was administered to her from 3/19/24 through 3/30/24. On 8/29/24 at 3:25 PM an interview with the MDS Nurse indicated she coded the medication section of Resident #64's 3/25/24 admission MDS assessment. She stated the section was coded in error, and it was her mistake. She went on to say she was not sure why she coded the assessment to reflect antianxiety medication was taken by Resident #64. On 8/29/24 at 3:50 PM an interview with the Director of Nursing indicated Resident #64's MDS assessments should be accurate.	F 641	current residents MDSs in the areas of antianxiety medication (Section N) to validate the most recent MDS assessment have been coded to accurately to reflect the status of the residents by the MDS Coordinator on 9/16/24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 9/16/24 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the new MDS Coordinator on accurately coding of antianxiety medications, (Section N) on 9/16/24. The Executive Director will conduct random Quality reviews of 5 residents MDS assessments in the areas of antianxiety medications (Section N) to ensure MDS coded accurately on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Date of Compliance 9/21/24.	
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		9/21/24

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F 677	Continued From page 9 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to keep dependent resident's fingernails trimmed for 1 of 6 residents reviewed for activities of daily living care (Resident #4). Findings included: Resident #4 was admitted to the facility on 2/10/23. His active diagnoses included muscle weakness, and other lack of coordination. Review of Resident #4's Minimum Data Set assessment dated 7/26/24 revealed he was assessed as moderately cognitively impaired. He was assessed to have no rejection of care and required substantial/maximal assistance with bathing and setup or clean up assistance with personal hygiene. Review of Resident #4's care plan dated 8/27/24 revealed he was care planned for an Activities of Daily Living self-care performance deficit related to impaired mobility. The interventions included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During observation on 8/26/24 at 2:29 PM Resident #4's fingernails were observed to be long.	F 677	F677-ADL Care Provided for Dependent Residents: 1. Resident #4 was provided nail care to include fingernails trimmed on 08/28/24. 2. The Director of Nursing completed a quality review on all residents on ADL care specific to nail care 8/28/24. Identified residents were provided nail care to include cleaning and trimming. On 9/16/24, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Clinical Services and or Nursing Supervisor. 3. The Director of Nursing, Nurse Manager or Director of Staff Development nurse re-educate nursing staff on all shifts by 09/19/24 on ADL care specific to trim nails on shower days, when observed to be long, and as indicated for all residents. Education will be completed by 09/19/24. 4. The Director of Nursing will conduct a random audit on 5 dependent residents, 3 times a week for 4 weeks, then weekly for 3 months, to ensure all nail care is being completed by keeping nails cleaned & trimmed as indicated. The Director of Nursing will report the results of the quality monitoring audits to the QAPI	

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F 677	Continued From page 10 During an interview on 8/26/24 at 2:30 PM Resident #4 stated his fingernails were long and he would love to have them cut. He further stated staff tell him it will be done but then something comes up and they are not cut. During observation on 8/28/24 at 10:11 AM Resident #4's fingernails were again observed to be long. During an interview on 8/28/24 at 10:13 AM Nurse Aide #3 stated Resident #4 did not refuse care and did not refuse care doing his morning bath. He stated when he provided morning care, he would check residents' nails. He stated if he noticed any resident's nails were long, he would clip them. The nurse aide concluded he did not clip Resident #4's nails that morning because he did not notice how long they were. During an interview on 8/28/24 at 10:16 AM the Director of Nursing stated nails were to be trimmed on shower days, when staff noticed long nails, or as needed. After observing Resident #4's nails, the Director of Nursing stated she would have expected staff to have noticed how long his nails were and trimmed them prior to now.	F 677	committee ensure compliance is achieved and maintained, monthly for three months and then quarterly for 2 quarters Findings will be reviewed by QAPI committee monthly and Quality monitoring will be updated as indicated. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse and at least one direct care staff. Date of Compliance on 9/21/24.	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Responsible Party (RP) and Physician interviews the facility	F 760	Past noncompliance: no plan of correction required.	

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failed to administer seizure medication to Resident #19 on 10/2/23 after he returned to the facility from the hospital, resulting in 4 missed doses of seizure medication. Resident #19 did not receive Keppra (an anti-seizure medication) beginning on 10/2/23 when he returned to the facility from the hospital through 10/4/23. On 10/4/23 Resident #19 suffered seizures in the facility, requiring readmission to the hospital. On 10/4/23 Resident #19 suffered a tonic/clonic seizure (loss of consciousness and violent muscle contractions which can be dangerous and potentially life threatening) lasting about 1 minute in the hospital which required the administration of intravenous (IV) Keppra. This was for 1 of 5 residents (Resident #19) whose medication administration was reviewed.

Findings included:

Resident #19 was admitted to the facility on 10/19/21 with a diagnosis of stroke (blockage of blood supply to the brain).

A review of Resident #19's care plan revealed a focus area last revised on 8/13/23 of seizure disorder related to stroke. The goal was for Resident #19 to have minimal risk of injury from seizure activity through the next review. An intervention was to administer Resident #19's seizure medication as ordered by his physician.

A review of a physician's progress note for Resident #19 dated 9/25/23 at 7:43 PM written by Physician #1 indicated Resident #19 was sent to the hospital Emergency Department (ED) on 5/25/2022 for seizure like activity where he was started on Keppra 500 mg by mouth twice daily.

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A review of Resident #19's September 2023 facility Medication Administration Record (MAR) revealed a physician's order with a start date of 5/22/23 for Keppra 500 milligrams (mg) by mouth twice daily for seizures. It further revealed documentation Keppra 500 mg was last administered to Resident #19 on 9/25/23 at 5:00 PM. The next dose due was on 9/26/23 at 9:00 AM.

A review of a nursing progress note for Resident #19 dated 9/26/23 at 8:14 AM written by Nurse #2 revealed Resident #19 was sent to the hospital emergency room for evaluation due to hypotension (low blood pressure).

A review of Resident #19's discharge Minimum Data Set (MDS) assessment dated 9/26/23 revealed he was severely cognitively impaired.

A review of Resident #19's hospital discharge summary dated 10/2/23 revealed Resident #19 was admitted to the hospital on 9/26/23 and treated for a urinary tract infection. He had history of seizure disorder. The list of his discharge medications included Keppra 500 milligrams (mg) by mouth twice daily.

A review of Resident #19's hospital MAR revealed documentation Resident #19 last received a dose of Keppra 500 mg by mouth on 10/2/23 at 9:01 AM in the hospital.

A review of a nursing progress note for Resident #19 dated 10/2/23 at 5:41 PM written by the Unit Manager revealed Resident #19 was readmitted to the facility.

A review of Resident #19's facility admission

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medication orders dated 10/2/23 at 5:00 PM entered into his electronic medical record by Nurse #2 did not reveal any evidence of the entry of an order for Keppra 500 mg daily.

A review of Resident #19's October 2023 facility MAR did not reveal any documentation Keppra 500 mg was administered to Resident #19 on 10/2/23, 10/3/23 or 10/4/23.

A review of a nursing progress note for Resident #19 dated 10/4/23 at 10:41 AM written by Nurse #2 revealed Resident #19 was sent to the hospital for treatment and evaluation of active seizures.

A review of Resident #19's hospital record dated 10/4/23 revealed Resident #19 presented to the hospital Emergency Department (ED) for evaluation of seizure like activity on 10/4/23 at 10:43 AM via Emergency Medical Services (EMS). EMS had reported no seizure like activity. Resident #19 initially had some altered mental status and was usually alert and oriented to himself but had not been alert at all that morning. He presented from his nursing facility with breakthrough seizures times three, followed by a prolonged postictal state (a period characterized by disorienting symptoms such as confusion, drowsiness, headache, and nausea that begins when seizure subsides and ends when a person returns to baseline). Resident #19 had reportedly been fine after his most recent return to the facility from the hospital on 10/2/23 until 10/4/23. On 10/4/23 Resident #19 was reported to have 3 separate seizures within a 5 minute period at the facility. Resident #19 had another tonic/clonic seizure on 10/4/23 at 11:34 AM in the ED which lasted about 1 minute. He was administered Keppra 1500 mg IV in the ED and Keppra 500 mg

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IV twice daily would be started in the morning on 10/5/23. Facility staff reported there had been a mistake when Resident #19 returned to the facility from the hospital on 10/2/23, and Resident #19 had not been given his Keppra for the last 2 days. Resident #19's seizures were most likely secondary to his inadvertent medication non-compliance. Resident #19 was discharged back to the facility on 10/6/23 with an order to continue his Keppra 500 mg by mouth twice daily.

On 8/29/24 at 9:04 AM an interview with the Unit Manager indicated when Resident #19 returned from the hospital on 10/2/23 Nurse #2 entered his medication orders into Resident #19's electronic medical record. She stated this was supposed to be done based on the medication orders that were listed on the hospital discharge summary, and Nurse #2 should have gotten a second nurse to check the medication orders she entered against Resident #19's hospital discharge summary to ensure the medication orders entered were accurate. The Unit Manager stated that because Resident #19's order for Keppra was not entered by Nurse #2 on 10/2/23, it did not appear of his Medication Administration Record to be administered to him, and he missed getting doses of this medication in the facility. In a follow-up interview on 8/30/24 at 11:56 the Unit Manager stated any nurse on the hall could enter a resident's hospital discharge medications into the electronic medical record when a resident returned from the hospital. She reported the nurse entering the medication orders should always have a second nurse verify the entered orders against the hospital discharge summary to ensure accuracy. She went on to say any second nurse could do the verification.

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On 8/29/24 at 7:07 PM a telephone interview with Nurse #2 indicated when Resident #19 was readmitted to the facility from the hospital on 10/2/23, she entered the medication orders from his hospital discharge summary into his electronic medical record. She went on to say she could not say why she missed entering Resident #19's Keppra medication order that day. She stated she was supposed to have another nurse check the medications she entered against the hospital discharge summary to ensure that the medications she entered for Resident #19 were accurate, but she had not. Nurse #2 stated she did not recall ever hearing anything about Resident #19's levetiracetam medication being missed. She reported she was caring for Resident #19 on 10/4/23 when he began having seizures. She went on to say she had been assigned to care for Resident #19 at times for the past 2 years that she had been working at the facility, and had never seen him have a seizure before. She stated Resident #19 began to have seizure activity which included jerking movements on 10/4/23, although she really couldn't recall any specific details. Nurse #2 further stated she had immediately notified the physician, and Resident #19 had been sent to the hospital that day.

On 8/29/24 at 10:09 AM a telephone interview with Resident #19's Responsible Party (RP) indicated Resident #19's seizures were diagnosed after he was admitted to the facility. She stated they had been handled at the facility with medication and he had not needed to go to the hospital for them previously. She stated in October 2023 Resident #19 had seizures, his physician wanted him sent to the hospital, and although she felt being sent out to the hospital was very disruptive for Resident #19, she had

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agreed. Resident #19's RP reported she did not feel that Resident #19 suffered any permanent changes in his mental or other abilities after the seizures he experienced in October 2023.

On 8/29/24 at 11:03 AM a telephone interview with Physician #1 indicated Resident #19 had been receiving Keppra for some time at the facility to treat seizures that were a result of his stroke. He stated Resident #19's seizures had been successfully managed in the facility. He went on to say when Resident #19 initially returned to the facility from the hospital on 10/2/23, there had been an error in transcription by the facility, and Resident #19's Keppra medication had not been restarted even though it appeared on his hospital discharge summary. Physician #1 reported as a result of this, Resident #19 had missed 2 to 3 doses of the Keppra medication in the facility that he should have received. He went on to say Resident #19 was very sensitive to low levels of the medication, and this resulted in Resident #19 experiencing seizures on 10/4/23. He reported Resident #19 required hospitalization for these seizures and needed doses of IV Keppra to control the seizures in the hospital. He stated Resident #19 had severe cognitive impairment at baseline, and although there was a very small risk of brain damage and/or death from the type of seizure Resident #19 experienced on 10/4/23, he did not feel Resident #19 had suffered any additional brain damage.

On 8/29/24 at 11:33 AM an attempt at telephone interview with Director of Nursing (DON) #2, the facility's DON on 10/4/23, using the telephone number provided by the facility's current DON, indicated the telephone number was no longer in

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service. No other telephone number for DON #2 was available.

On 8/29/24 at 1:13 PM an interview with the facility's Consultant Pharmacist indicated it was likely that Resident #19 experienced seizure activity on 10/4/23 as a result of his missed Keppra medication. She stated while the pharmacy did review resident's readmissions to the facility, comparing the medication orders entered by the facility with the hospital discharge summary to ensure accuracy, a review of Resident #19's readmission medication orders would not have occurred until 10/4/23 after he had already been readmitted to the hospital.

On 8/29/24 at 2:50 PM a telephone interview with Administrator #2 indicated he was no longer the facility's Administrator but had been on 10/4/23. He stated he did not recall whether the issue with Resident #19 missing doses of Keppra medication had been discussed while he was the facility's Administrator. He reported he had held daily morning clinical meetings, and if this issue had been discussed, there should be documentation of that.

On 8/29/24 at 2:56 PM an interview with the facility's current Administrator indicated he had not previously been aware of the incident with Resident #19 missing doses of Keppra medication. He stated he had not been the Administrator at that time and was not aware of any corrective action plan for the incident. On 8/30/24 at 12:31 PM a follow-up interview with the Administrator indicated he had not been able to find any documentation that the issue with Resident #19 missing his Keppra medication in October 2023 had been discussed at a clinical

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meeting.

On 8/30/24 at 12:22 AM an interview with the DON indicated she was not the DON at the facility on 10/4/23 and had not previously been aware of the issue with Resident #19 missing his levetiracetam medication. She stated when a resident was readmitted to the facility from the hospital, the nurse entering the resident's medication orders into the electronic medical record should enter these based on the discharge medications listed on the resident's hospital discharge summary. She stated a second nurse should also verify that the medication orders entered were accurate based on the discharge medications listed on hospital discharge summary to prevent any errors.

The Administrator was notified of Immediate Jeopardy on 8/29/24 at 2:30 PM.

The Administrator provided the following corrective action plan with a compliance date of 10/30/23:

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

On 10/4/23 Nurse manager identified that between 10/2/23 and 10/4/23 resident #19 had a total of 4 doses of Keppra omitted due to a transcription error at readmission by the center 10/2/23. Orders were obtained for Keppra 500mg BID when returned from hospital on 10/6/23. The center recognizes that all newly admitted residents and residents that are readmitted have the potential to be affected from the prior noncompliance with obtaining and administering

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medications.

A review of Resident #19's hospital medication administration record dated 10/2/23 at 2:01 PM revealed Resident #19's last administered dose of Keppra 500 milligram (mg) orally in the hospital was on 10/2/23 at 9:01 AM. The order was for Keppra 500 milligram (mg) orally twice daily. There was no documentation he received any Keppra after returning to the facility on 10/2/23. There was no documentation of any doses administered in the facility on 10/3/23, and no documentation of doses in the facility on 10/4/23 before Resident #19 was transferred to the hospital on 10/4/23. He arrived at the hospital at 10:43 AM on 10/4/23. That adds up to 4 missed doses.

All newly admitted residents and readmitted residents between 9/4/23 through 10/4/23 have had their medication orders audited by the Director of Clinical Services and Unit Managers. No discrepancies were noted.

On 10/4/23 a Root Cause Analysis was completed by the Director of Nursing, and the Administrator regarding omission of medication administration for resident #19. It was determined through root cause and analysis that the medication was not administered due to the oversight of transcribing the orders.

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

A quality review was completed on 10/5/23 of current residents with a diagnosis of seizure disorder. Identified residents were reviewed by

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the Director of Nursing and Nurse Managers to ensure all seizure medication was ordered, transcribed correctly, and given as ordered.

A quality review of all admissions and re-admissions 30 days prior to October 4th, 2023, was conducted by the Director of Nursing and Unit Manager to ensure all other newly admitted or readmitted patients' medications were administered per Physician orders. There were no medication transcription errors noted during the quality review.

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

The Director of Nursing and/or the nurse managers provided education on 10/4/23 to current nurses and med aides on the importance of transcribing all new orders from discharge summaries, verified by 2 nurses to ensure medications are transcribed and administered per physician orders to the residents. Newly hired nurses and med aides will be educated on hire during their orientation process. The Administrator provided oversight for the education of nurses and med aides to ensure that 100% of all licensed staff and med aides were reeducated on the importance of administering all ordered medications.

The Director of Nursing and Nurse Managers will conduct Quality Improvement Monitoring of medication administration records of all new residents when admitted or readmitted to facility to ensure all medications are transcribed correctly and medications are administered as ordered per Physician starting 10/4/23. Upon receiving

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discharge summaries medication orders are verified with Provider, 1 Nurse transcribes all orders, and then 1 Nurse verifies/confirms that orders were transcribed correctly. This is the standard process that is in place.

Additionally, the Director of Nursing and Nurse Managers will conduct quality improvement monitoring of all admissions/readmissions to ensure all medications are transcribed to medication record as indicated. The above Quality Improvement Monitoring will occur daily in clinical for 4 weeks, then weekly for 3 months ongoing beginning 10/4/23.

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

On 10/04/2023, when the deficient practices was identified the center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting to determine the root cause analysis of the deficient practice, put a plan of action in place to include quality improvement monitoring and the frequency of monitoring beginning on 10/04/2023 to ensure medication administration orders were transcribed correctly and medications were administered as ordered including the Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, the Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records Clerk, Central Supply Clerk, Admissions Director, Nurse Managers, Dietary Manager, and the Environmental Services Director.

The results of the quality monitoring will be

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F 760	Continued From page 22 brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance times 4 months. Quality Improvement monitoring schedule will be modified based on findings of monitoring. The center Administrator alleges abatement of immediacy on 10/30/23. Validation of the corrective action plan was completed on 9/04/24. Interviews were conducted with a sample Nurses to verify education was conducted for Nurses regarding transcription of medication to the Medication Administration Record (MAR). Documentation of in-service records was reviewed. A review of audits of new admissions and their orders transcribed to the MAR dated 9/4/24 to 10/4/24 were verified to be completed. In an interview with the Nurse Manager on 9/4/24 at 1:18 pm, she stated that all Nurses, and Medication Aides had been educated transcribing medication on the MAR and 2 nurses reviewed to confirm accuracy of the transcription. She further stated that orientation included medication administration and transcription of medication orders to the MAR. An observation of the Resident #19's medical record revealed that Resident #19 had received all prescribed doses of Keppra (an antiseizure medication) from October 2023 (after the identified date of missed October 2023 doses) until today 9/4/24. The QAPI minutes were reviewed. The facility's alleged immediate jeopardy removal date and compliance date of 10/30/23 was verified.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		9/21/24

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F 761	Continued From page 23 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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 and staff interviews the facility failed to secure resident medications stored in an unattended medication cart (Rooms 143-150 hall) for 1 of 5 medication carts. Findings included: A continuous observation was conducted of the medication cart on 8/27/24 from 8:35 AM to 8:47 AM. The cart was parked between rooms 144 and 146, facing out into the hallway. The cart was	F 761	F761- Label/Store Drugs and Biological 1. The Director of Nursing observed Medication Aides during their medication pass to ensure they are always locking their cart when left unattended on 08/27/24. The Director of Nursing observed that all 5 medication carts are securely locked to ensure that all 5 medication carts locks are in working order on 08/27/24. 2. The Director of Nursing conducted	

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F 761	Continued From page 24 visible from the nurse's station but there were no staff there. There were two Nurse Aides passing breakfast trays on the hall. No residents were observed near the medication cart. The medication cart was observed to have the red dot on the push lock visible, which meant the push lock was not engaged. There was no staff member with the medication cart. Medication Aide #1 came out of resident room number 150 which was at the end of the hall on the opposite side. She returned to the medication cart at 8:47 AM. Medication Aide #1 opened the top drawer without having to unlock the cart. During an interview with Medication Aide #1 at 8:47 AM she stated she left the medication cart unlocked. She further stated the cart should be locked any time she was not using it. In an interview with the Director of Nursing (DON) on 8/27/24 at 8:52 AM she stated the medication cart should be locked when the Medication Aide was not using it. An interview with the Administrator on 8/27/24 at 8:54 AM revealed medication carts should not be unlocked unless the Medication Aide was using it. The Administrator stated the Medication Aide assigned to that medication cart was responsible for it for their entire shift.	F 761	random audits of Medication Aides during their medication passes to ensure they never leave the medication carts unsecure when walking away on 08/27/24 and visualized that the red dot on the push lock is not visible, ensuring it is locked. An ADHOC Quality Assurance Performance Improvement Committee will be held on 09/16/2024 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Staff Development re-educated Medication Aides & Nurses on the importance of making sure all medication carts are locked when left unattended beginning on 08/27/24. New hire Medication Aides will be educated during the orientation process. Education will be completed by 09/19/24. 4. The Director of Nursing and Unit Managers will conduct random audits on 5 medication carts weekly for 12 weeks to ensure no medication carts are left unlocked and unattended. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. Date of Compliance on 9/21/24.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		9/21/24

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 26 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement their hand hygiene policy when the Respiratory Therapist (RT) failed to perform hand hygiene after touching a contaminated surface and before touching the tracheostomy and failed to implement their policy for enhanced barrier precautions when the RT failed to wear a gown while performing tracheostomy care for 1 of 1 resident (Resident #53) reviewed for tracheostomy care, and failed to perform hand hygiene between the removal of soiled gloves and the application of clean gloves for 1 of 2 residents (Resident #71) reviewed for pressure ulcers.	F 880	F880- Infection Prevention Control: 1. The Director of Nursing conducted surveillance to ensure respiratory therapy used standard and transmission-based precautions including hand hygiene when providing tracheostomy care for resident #53 on 09/12/24. The Director of Nursing conducted surveillance to ensure nurses are using standard and transmission-based precautions including but not limited to hand hygiene when performing treatment for resident #71 who has pressure ulcers on 08/30/24. 2. The Director of Staff Development will complete competencies on Respiratory	

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F 880	Continued From page 27 Findings included: 1. A review of the facility policy titled "Handwashing/Hand hygiene" dated August 2019 provided by the facility stated in part: "This facility considers hand hygiene the primary means to prevent the spread of infection. 7. Use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: e. before or after handling an invasive device (e.g. urinary catheters, IV access sites). :g. before handling clean or soiled dressings, gauze pads, etc. :l after contact with objects in the immediate vicinity of the resident." A review of the enhanced barrier precautions policy stated in part: "gown and gloves must be worn when providing personal care." Tracheostomy care is given as an example of care provided. During an observation of tracheostomy care by the RT on 8/27/24 at 4:47 PM, she failed to don a gown before entering Resident #53's room who was on enhanced barrier precautions. There was a sign on the door specifying staff wear a gown when performing care such as tracheostomy care. The RT stated that tracheostomy care was a clean procedure not a sterile procedure. She put on a pair of clean gloves, then put a pair of sterile gloves on over the clean gloves. Resident #53 requested she turn up the air conditioning. She went to the air conditioner and touched the button to turn it up. The RT continued to set up the sterile disposable cartons to pour sterile water and hydrogen peroxide into. She continued to pour the liquids into their containers and put	F 880	Therapy and nurses to ensure proper use of standard and transmission-based precautions are used when providing tracheostomy care to prevent infections by 9/19/24. The Director of Staff Development will complete competencies on nurses and Respiratory Therapy to ensure proper use of enhanced barrier precautions by 9/19/24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 09/16/2024 to formulate and approve a plan of correction for the deficient practice. 3. The Respiratory Therapist providing tracheostomy care for resident #53 was re-educated by the Director of Staff Development on 09/12/24 to ensure Respiratory Therapist demonstrated tracheostomy care per policy. The Director of Staff Development re-educated the treatment nurse who provided wound care for resident #71 to ensure wound care is provided per policy on 08/30/24. 4. The Director of Nursing will conduct random audits on Respiratory Therapy and nurses to ensure they are using transmission based and standard precautions using hand hygiene when providing tracheostomy care weekly for 12 weeks. The Director of Nursing will conduct random audits on enhanced barrier precautions when providing wound care 3 times a week for 12 weeks. The Director of Nursing will provide the results of the quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality audits will be updated as	

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F 880	Continued From page 28 gauze into them with her gloved hands. The RT proceeded to take out the resident's dirty disposable cannula and dispose of it. She then removed the dirty split sponge from under the resident's tracheostomy collar and disposed of it. The RT proceeded to put her gloved hand into the container with sterile water and gauze, picked up the gauze, squeezed out the excess water and proceeded to clean around the tracheostomy stoma. Resident #53 stated the stoma was tender. The RT retrieved her cell phone from the pocket of her top, turned on the flashlight and looked at the stoma by moving the collar with her gloved hand. After she put the phone away, she continued to clean around the stoma with wet gauze. When finished cleaning, she put the new, sterile cannula in. The RT then took off the outer layer of gloves and proceeded to change the residents trach collar. At this point she was finished. In a telephone interview with the RT on 8/30/24 at 8:50 AM she revealed she did not know if she was to wear a gown while providing tracheostomy care on a resident on enhanced barrier precautions. The RT stated she was taught that tracheostomy care was not a sterile procedure. She was unaware of the policy she was to follow to provide care. The RT revealed she was aware she should not have touched potentially dirty surfaces and continued with care without performing hand hygiene due to the risk of introducing harmful bacteria to the resident. A telephone interview was conducted on 8/30/24 at 3:50 PM with the RT Supervisor. The Supervisor stated a gown should have been worn to perform tracheostomy care and the RT should have performed hand hygiene after touching	F 880	indicated. Date of Compliance on 9/21/24.	

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potentially dirty surfaces and before performing care on the resident. The Supervisor further stated the RT works for a contracted company, not the facility and as such, should have followed the tracheostomy care policy of the facility.

In an interview with the Director of Nursing (DON) on 8/29/24 at 12:53 PM she stated the RT worked for a contracted company and she was not sure which policy the RT should have followed. She further stated the RT should have worn a gown to perform tracheostomy care due to enhanced barrier precautions and should have performed hand hygiene by washing her hands and donning clean gloves after touching a dirty surface and before continuing tracheostomy care on Resident #53.

2. A review of the facility policy titled "Handwashing/Hand hygiene" dated last revised August 2019 provided by the facility revealed in part: "This facility considers hand hygiene the primary means to prevent the spread of infection. 7. Use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. After removing gloves."

On 8/27/24 at 3:21 PM an observation of pressure ulcer care was conducted for Resident #71 and the observation was followed by an interview with the Treatment Nurse who was performing the dressing change. During the observation, the Treatment Nurse was observed to perform hand hygiene and apply clean gloves. She removed the soiled dressing from Resident #71's left ischium (lower and back region of the hip bone) pressure ulcer using her gloved fingers

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and discarded the soiled dressing. The Treatment Nurse removed her soiled gloves, discarded them, and applied clean gloves without performing hand hygiene. As the Treatment Nurse reached for the wound cleanser moistened gauze to clean Resident #71's wound, she was asked to pause the dressing change. An interview with the Treatment Nurse at that time indicated she had not performed hand hygiene after removing the soiled dressing from Resident #71's pressure ulcer before she applied her clean gloves, and she should have. The Treatment Nurse reported she usually performed hand hygiene after the removal of her soiled gloves prior to applying clean gloves, but she had been nervous and forgotten. She stated performing hand hygiene after removal of soiled gloves before applying clean gloves reduced the chance of spreading infection.

On 8/30/24 at 12:22 PM an interview with the Director of Nursing (DON) indicated the Treatment Nurse's gloves would have been soiled after she removed Resident #71's soiled dressing. She stated hand hygiene should always be performed after the removal of soiled gloves prior to the application of clean gloves to reduce the chance of the spread of infection.