STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING ______ B. WING ______	C 09/12/2024

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 8/28/24 to conduct a complaint survey and exited on 8/31/24. Additional information was obtained through 9/12/24. Therefore, the exit date was changed to 9/12/24. (Event ID# KPS611) The following intakes were investigated: NC00220528, NC00220672, NC00220759, NC00220811, NC00220937, NC00220962, NC00221112, NC00221200, NC00221227, NC00221442, NC00221721, NC00221810 Thirty (30) of forty-seven (47) complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.12 at tag F600 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity K The tags F 600 and F 684 constituted Substandard Quality of Care. Immediate Jeopardy began on 6/28/24 and was removed on 9/9/24. A partial extended survey was conducted.	F 000		
F 550 SS=G	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.	F 550		10/14/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/07/2024

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 550	Continued From page 1 §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 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 observation, record review, and interviews with resident, staff, and Nurse Practitioner the facility failed to ensure Resident # 1 was afforded dignity while residing in the facility.	F 550	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth	

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F 550	Continued From page 2 Resident # 1, who was documented to be a bedbound resident, was found with multiple maggots located in her bed, under her breast, and within her contracted hand. Prior to the maggots being found on Resident # 1, staff had observed multiple flies in the resident's room, landing on the resident, and in other parts of the facility. This was for one (Resident # 1) of five residents reviewed for respectful treatment by staff. (Resident # 1 had mental illness and was unable to express harm a reasonable person would express if they had multiple maggots located on them while relying on others for care. Therefore, the reasonable person concept was applied in determining severity to this citation). The findings included: Resident # 1 was admitted to the facility on 3/1/17 and had diagnoses in part which included a degenerative neuromuscular disease and bipolar disorder with psychotic features. Resident # 1's quarterly Minimum Data Set assessment, dated 6/19/24, coded Resident # 1 as cognitively intact and as being totally dependent on staff for bathing, dressing, hygiene, and bed mobility. Review of nursing notes revealed an entry by Nurse # 1, dated 8/11/24 (Sunday) at 5:57 PM, noting a new order for Resident # 1's care. The nurse documented, "Noted right hand contracture below the fingers cleanse with wound cleanser Xerofoam drsg (dressing) apply then cover with dry dressing change Tuesday, Thursday, Saturday and PRN (as needed)." Nurse #1 also noted the resident's family was called and notified. The note did not signify the problem with the hand other than the resident had a	F 550	in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F550 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 head to toes skin inspection was conducted by the Unit Coordinator #1 on 10/7/2024. No new skin alterations and/or Maggots identified on resident #1, no other actions taken for resident #1. Identification of other residents having the potential to be affected by the same deficient practice: 100% of skin inspection for all current residents in the facility conducted between 09/19/2024, by Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2, to identify any other resident with maggot(s) in their wounds or any parts of their body. No other resident identified to have maggots on their body. Findings of this audit are documented on a skin inspection tool located in the facility compliance binder. 100% inspection for all current residents in the facility conducted on 10/07/2024, by Director of Nursing, Unit coordinator #1, Unit coordinator #2, and/or scheduler to identify any other resident with flies landing on their body while in the facility. No other resident identified to have flies landing on their body. Findings of this audit are documented on a Flies inspection tool located in the facility	

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contracture.

On 8/13/24 (Tuesday) Nurse Practitioner # 1 documented she saw Resident # 1 and noted the following information. The resident was grimacing when her hand was touched. She was a bedbound resident and was being seen for follow up after living larvae had been identified in her right hand/fingers and manually removed. Hygiene care had been provided and an antibiotic ointment applied. Oral antibiotics had been initiated also. At the time NP # 1 saw the resident the resident had no agitation or anxiety and was at her baseline. There was mild swelling of her right hand fingers, and fingers 3 to 4 were tender to touch. There was no drainage or redness.

Nurse # 1 was interviewed on 8/30/24 at 5:45 PM and reported the following. During the weekend prior to Resident # 1 being seen by the NP on 8/13/24 (Tuesday), the resident had been complaining of her hand hurting. She had a contracted hand. She (Nurse # 1) soaked the resident's hand and did the best to clean the hand. Resident # 1 had a carrot device that she was to keep in the hand for the contracture, but the resident did not always keep the carrot in her hand. The Nurse Aides said the resident would refuse care at times. At the time she saw Resident # 1 on the weekend, there were no maggots in her hand.

The weekend Treatment Nurse was interviewed on 8/31/24 at 9:30 AM and reported the following information. On 8/11/24 MA (Medication Aide) # 1 told her Resident # 1 had some dried blood on her hand. The weekend Treatment Nurse also knew that on 8/10/24 (Saturday) Nurse # 1 said that therapy had been working with the resident

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compliance binder.
Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:

Effective 10/07/2024, the facility staff will 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, to include ensuring each resident is clean and free from maggots and flies on their body. These systemic changes will be accomplished by implementing the following measures:

Effective 10/07/2024, the Clinical team, which consists of the Director of Nursing, Assistant Director of Nursing, Minimum Data set (MDS), and/or Unit coordinators (#1, #2), will incorporate the process for reviewing completion of skin inspection to ensure that each resident has a completed skin inspection weekly and assure no maggots are identified in resident skin. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting.

DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this

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F 550 Continued From page 4

and her hand was bleeding. Resident # 1 had a carrot device to keep in her hand for her contracture. On Saturday, Nurse # 1 took care of the resident's hand because she (the weekend treatment nurse) had been busy. When she (the weekend treatment nurse) saw Resident # 1's hand on 8/11/24 (Sunday) there was no active bleeding. In her right contracted hand, the resident had fragile skin where she had previous skin breakdown. Within the fragile skin the resident appeared as if she had a very small puncture wound from her fingernails being against the palm of her skin. She (the weekend treatment nurse) used a cotton tipped swab to clean the wound and she applied a dressing. At the time she did not see any signs of maggots in the resident's hand or wound. The resident had refused to have her nails trimmed and cared for. She had seen flies in Resident # 1's room and she had also seen flies in other parts of the facility landing on people.

MA # 1 was interviewed on 8/29/24 at 2:38 PM and reported the following information. She had cared for Resident # 1 both on 8/10/24 (Saturday) and 8/11/24 (Sunday). On 8/10/24 (Saturday) Resident # 1's Nurse Aide (NA) had told her that it appeared as Resident # 1's hand was bleeding. She told Nurse # 1. On 8/10/24 (Saturday) there were a lot of flies in Resident # 1's room. MA # 1 estimated there were about 12 or so flies in the room on that date. She (MA # 1) was "swishing, swishing, swishing" trying to get them away from the resident and out of her room to the best of her ability. Flies would land on the resident, who tended to keep food items resting on her chest as she ate in the bed. MA # 1 also was aware blood from the resident's hand might attract the flies to her. The Maintenance Director was aware flies

F 550

education will be the maintaining resident□s rights and treating each resident with dignity and respect including ensuring each resident is free from maggots. The education also emphasized the importance of completing skin inspection weekly. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/7/2024, DON and/or ADON will monitor compliance with completion of skin inspection by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced skin inspection schedule to assure completion and identification of any new alterations to include maggots. Any negative findings will be addressed promptly by the DON and/or ADON. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained.
Effective 10/07/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of

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F 550	Continued From page 5 were in the facility. It was her understanding that the problem with flies had been added to the maintenance log and he had been told multiple times. She (MA #1) could not go to the nursing desk and sit down without flies following her. On Sunday 8/11/24, she knew the weekend Treatment Nurse had cared for Resident # 1's hand and cleaned it well. She (MA # 1) never saw maggots on Resident # 1 during the weekend. According to staffing records, Nurse # 8 had cared for Resident # 1 on the shift which began at 11:00 PM on 8/11/24 (Sunday night). Nurse # 8 was interviewed on 8/29/24 at 7:56 PM and reported she had not seen maggots on Resident # 1 during her Sunday night shift which began on 8/11/24. She had not seen flies in the room. MA # 2 was interviewed on 8/29/24 at 3:21 PM and reported the following information. She had been assigned to care for Resident # 1 on 8/12/24 (Monday) when the maggots were found on Resident # 1. She had started her medication pass when Resident # 1's Nurse Aide #2 came to her and reported Resident # 1 had maggots on her. She (MA # 2) alerted a nurse who also alerted the former DON (Director of Nursing). On 8/12/24 MA # 2 had seen a fly in Resident # 1's room. MA # 2 reported the room did not appear to be infested with flies when she was there. Nurse Aide # 2, who had been assigned to care for Resident # 1 on 8/12/24 (Monday), was interviewed on 8/29/24 at 7:47 PM and reported the following information. On 8/12/24 she was turning and providing a bath for Resident # 1 when she saw maggots in the bed. She went to Unit Manager # 1 to report the issue and they both looked and saw the maggots. Then the	F 550	compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	

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F 550	Continued From page 6 ADON (Assistant Director of Nursing) and former DON (Director of Nursing) were asked to come and help. At the time NA # 2 recalled seeing at least three in the resident's bed and at least one on her body. The DON picked the maggots off the resident. The resident's hand was contracted at the time and the resident was holding a gauze pad in her hand. She (Nurse Aide #2) had not seen the maggots in her hand. The resident had pain in her hand and did not want staff to do anything with the hand on that day. Prior to 8/12/24, the resident would at times refuse care to her hand if she did not know the staff member well who was trying to provide care. She (Nurse Aide # 2) left at 3:00 PM on 8/12/24 and did not know what happened with the resident' s hand after that. She did see flies "everywhere" in the facility and had seen them at times land on residents. Nurse Aide # 1 was interviewed on 8/29/24 at 4:40 PM and reported the following information. She had been working on 8/12/24 and had helped Nurse Aide # 2 with Resident # 1. She knew NA # 2 had been told to clean the resident's bed and body. She (NA #1) saw multiple maggots on the resident and in her bed as she was helping care for the resident. It was her understanding the maggots had crawled out from the resident's hand. The "higher ups" (including the former DON) had been present in the room to deal with the maggots. Flies had been a problem in the facility. She (NA # 1) saw them daily and they would at times land on residents. Unit Manager # 1 was interviewed on 8/31/24 at 10:38 AM and reported the following information. She had heard about the maggots being on Resident # 1, and the former DON had dealt with	F 550		

F 550 Continued From page 7 F 550

the maggots. When she was called into the room, she (Unit Manager # 1) pulled back the covers but did not personally see them.

NA # 3, who at times cared for Resident # 1, was interviewed on 8/29/24 at 12:40 PM and reported the following information. She had never witnessed maggots in Resident # 1's hand. She did know the resident's hand hurt at times and she would not allow the staff to care for the hand at times. She (NA # 3) did see flies in the facility. She saw flies "all the time" and she was aware residents complained about them.

The ADON (Assistant Director of Nursing) was interviewed on 8/29/24 at 11:30 AM and reported the following information. It was her understanding that the maggots had been found when the resident was being given a bath one day. The former DON (Director of Nursing) had dealt with the issue and given direction to the wound nurse to assess and clean the resident's hand.

The facility's weekday treatment nurse was interviewed on 8/30/24 at 5:15 PM and reported the following information. She (the weekday treatment nurse) had been told the resident had maggots in her hand on 8/12/24 (Monday). She had not personally seen them. She had not witnessed flies landing on Resident # 1, but she had seen flies in her room. She had also seen them in the facility on a daily basis.

Resident # 1 was interviewed and observed on 8/29/24 at 8:20 AM. At the time she was observed to have a right hand contracture. When interviewed about her care in general, the resident did not initially bring up the maggots

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during conversation. She tended to wander in her conversation from topic to topic. While talking about something else, she abruptly mentioned she had neuropathy in her hand and at one time had maggots in her hand. She then went off topic again and did not expound further.

Interview with the Maintenance Director on 8/29/24 at 4:20 PM revealed he had been employed at the facility for about a month. He had not been aware there had been a problem with a specific resident having any medical issues related to flies in their room. He was aware there were flies in the facility and he had called a pest control company, and the company's technician had not visited that month as of 8/29/24.

The former DON, who had reportedly removed the maggots, was not available for interview during the survey.

Nurse Practitioner # 1 (NP#1) was interviewed on 9/5/24 at 8:55 AM and reported the following information. She had been called on 8/12/24 and told the resident had maggots on her. She had been informed that there had been approximately 26 maggots removed from her. At the time she was called, she was told that the resident's hand had been cleaned with soap and water, a triple antibiotic topical cream had been applied to her hand, and the resident was not in distress. On 8/13/24 she saw the resident for evaluation. The resident was placed on an antibiotic to prevent any problems. The resident was considered to be cognitively intact but also had some mental illness. The resident tended to talk to non-existent people at times and when she (NP # 1) tried to talk to Resident # 1 on 8/13/24 the resident was doing so. The resident also had some short term

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F 550	Continued From page 9 memory problems. During the 8/13/24 assessment, there was a disruption of the resident's nail bed on fingers three and four of her right hand. She (NP #1) could tell the maggots had been under the nails and in the nail bed. There was some slight inflammation around the nail beds and no wound in the palm of her hand at the time of assessment. The resident had not been aware the maggots had been in her hand before they were identified on 8/12/24. Due to the resident's medical diagnoses, the resident did not have the sensation in the hand to detect that they had been in her hand, and she did not have the mobility to move away from flies. The resident tended to keep snacks in her room. If she had gotten some food in her hand without adequate hygiene, then flies could have landed on her hand and laid eggs. It did not take long for a fly to do this. When she assessed Resident # 1's hand on 8/13/24 there was some warmth around her hand which involved her wrist and palm as well. This appeared to have come from the maggots being in her hand and the NP estimated from the amount of inflammation in the hand, she felt the maggots had been in her nail beds and under her fingers for at least 24 to 48 hours prior to being removed. She did have some routine pain in her contracted hand but some of the pain she was reporting at time of assessment on 8/13/24 was also due to the maggots being in her hand. The resident tended to not be trusting of staff if she did not know them due to her mental illness. If she had refused care, her distrust of some new staff members may have contributed to refusal of hygiene. The NP felt the staff should be patient and try to build a trusting relationship with the resident so she would consistently accept hygiene assistance.	F 550		

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F 550	Continued From page 10 The facility's corporate Nurse Consultant was interviewed on 8/30/24 at 6:00 PM. According to the Corporate Nurse Consultant the former DON had not informed the Administrator or corporate employees of any problems with the resident having maggots in her bed and on her. If the former DON had done so, the issue of flies in the building would have been addressed and a plan to prevent the problem from reoccurring would have been initiated. He had learned that day that the facility did not have a pest control contract with a service provider. When the facility recently underwent new ownership, there had been miscommunication with the pest control company and the service contract had not been extended. The facility had not had pest control services since 5/15/24.	F 550		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff the facility failed to ensure a	F 559	F559 Corrective actions accomplished for those	10/14/24

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resident was allowed the opportunity to see the room and meet the roommate prior to being moved to a new room within the facility. This was for one (Resident # 19) of one resident reviewed for room change notification. The findings included:

Resident # 19 was admitted to the facility on 12/5/23.

Review of Resident # 19's quarterly Minimum Data Set assessment, dated 8/2/24, revealed the resident was assessed to be cognitively intact.

A nursing noted on 8/26/24 noted that Resident # 19 was notified of a room change for medical management reasons. The resident's record indicated the room change occurred on 8/27/24. The record also indicated the resident's responsible party was given written notification of the room change prior to the room change.

Resident # 19 was interviewed on 8/29/24 at 9:15 AM and reported the following information. She had been told on 8/26/24 (Monday) that she had to move because of insurance reasons. Previously she had resided in a private room. She was not allowed to see the new room or meet her new roommate prior to the room change that occurred on 8/27/24. She was not happy with the room change. Her roommate would call out and was confused. It disturbed her at night, and she had not slept well. If she was to have a roommate she would like to have someone with whom she could converse.

The facility social worker (Social Worker # 1) was interviewed on 8/29/24 at 2:58 PM and reported the following information. He was newly employed

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residents found to be affected by the deficient practice:
Resident #19 was interviewed on 10/07/24 by Assistant Administrator to see if she would like to have a room change from the one, she was moved to, but resident #19 declined to move on 10/07/24.
Identification of other residents having the potential to be affected by the same deficient practice:
100% audit of all residents who had a room changes happened in the last 30 days was completed on 10/07/2024 by Assistant Administrator to ensure that they were offered the option to view the room and meet the roommate if any. This audit is documented on room changes notification assessment located in the facility electronic health
Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:
Effective 10/07/2024, when a resident is being moved at the request of facility staff, the resident, family, and/or resident representative will receive an explanation in writing of why the move is required.

Effective 10/07/2024, the need for a room change will be discussed in the daily stand-up meeting that takes place Monday through Fridays by the Admission coordinator and/or designated person.

Effective 10/07/2024, following the room change need discussed in the daily meeting, the facility social worker will visit the resident and provide an opportunity to

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F 559	Continued From page 12 to the facility and had been at the facility for about two weeks. During the morning administration "stand up" meeting, room changes routinely were discussed, and the admissions coordinator handled which rooms residents were to be reassigned when the need arose for a room change. He was not aware that residents were to be allowed to see the room before a room change or to meet their new roommate or he would have made sure that had occurred for Resident # 19. He wanted residents to be happy and would have worked with the resident more to find a room she liked. The facility admissions coordinator was interviewed on 8/30/24 at 11:00 AM and reported the following. The business office routinely alerted her when there was a change in payment for rooms and she then assigned a new room that was open for a resident.	F 559	see the new location, meet the new roommate, and ask questions about the move, and complete the room change notification form, and document in electronic health records. Assistant Administrator will complete an education to the facility social workers, Admission coordinator, and Director of nursing. The emphasis of this education will be the importance of discussing room changes in the daily stand-up meeting. The education also emphasized the importance of social worker to visit the resident and provide an opportunity to see the new location, meet the new roommate, and ask questions about the move, and complete the room change notification form, and document in electronic health records. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for social workers, Admission coordinators and Director of Nursing Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/7/2024, the Assistant Administrator will review all room moves that were completed in the last 24 hours or from the last stand-up meeting to ensure that a written notice was provided, documented and indicating that resident had the opportunity to view the room, and meet the roommate (if any). This monitoring process will be conducted	

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F 559	Continued From page 13	F 559	twice weekly for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. The findings of this process will be submitted to QAPI for review and recommendation by the Assistant administrator and/or social worker monthly for three months or until the pattern of compliance is maintained. Completion date: 10/14/2024	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		10/14/24

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F 580	Continued From page 14 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, family, and physician interview, the facility to provide accurate notification to the physician of repeated episodes of Resident 22's blood glucose level registering greater than 400 milligrams per deciliter (mg/dL) (normal blood glucose level are considered to be between 70 mg/dL to 100 mg/dL) over two days and to notify the resident's physician and family when Resident #22 was found to be nonresponsive by a physical therapy staff member hours before Emergency Medical Services (EMS) was called. Resident #22 was found with an elevated heart rate of 140 beats per minute (bpm) (a typical resting heart rate for	F 580	F580 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #22 no longer in the facility, no other actions taken for resident #22 Identification of other residents having the potential to be affected by the same deficient practice: Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other	

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adults is between 60 and 100 bpm), respirations in the 40s breaths per minute (a normal respiratory rate is between 12 and 20 breaths per minute), and with a continued reading of a blood glucose level more than 400 mg/dL at time of transport by EMS. At the time of ED (emergency department) physician assessment, Resident # 22 was diagnosed with sepsis (a life-threatening complication of an infection) and hyperglycemia. (Hyperglycemia is the technical term for high blood glucose levels that occurs due to the body having too little insulin or when the body can't use insulin properly.) This was for one (Resident #22) of three residents reviewed for notification of physician for a change in medical condition.

Immediate jeopardy began on 7/10/2024 when Resident #22 was identified as having a blood glucose reading of over 400 mg/dL and the physician was not notified. Immediate Jeopardy was removed on 9/9/2024 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective.

Findings included:

Resident #22 was originally admitted to the facility on 8/2/2023 and readmitted on 6/21/2024 with multiple diagnoses which included type 2 diabetes mellitus.

Documentation in a physician order dated 6/22/2024 revealed Resident #22 was ordered to receive Novolog insulin solution to be injected subcutaneously (under the skin) three times day

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resident with the change condition that require medical attention and/or notification to the physician. The clinical assessment focused on resident□s vital signs to include, blood pressure reading, pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated. 100% audit of all current resident□s blood glucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a resident with episodes of hypoglycemia and/or hyperglycemia to ensure notification to the attending physician was made. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician of appropriate measures and or interventions and implement the interventions as ordered.

Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:
Effective 09/07/2024, facility employees will ensure significant changes, to include

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at 8:00 AM, 12:00 PM, and 4:00 PM per the following sliding scale: If the blood glucose level was 201 mg/dL to 250 mg/dL administer 4 units; 251 mg/dL to 300 mg/dL administer 6 units; 301 mg/dL to 350 mg/dL administer 8 units; 351 mg/dL to 400 mg/dL administer 10 units; greater than 400 mg/dL call the physician. Novolog is a fast-acting insulin used to treat high blood glucose for people with diabetes.

There was no documentation on the July (Medication Administration Record) (MAR) Resident #22 had a blood glucose level taken or received Novolog insulin as ordered at 8:00 AM on 7/10/2024.

Documentation on the July MAR revealed Medication Aide (Med Aide) #4 took a blood glucose level of 400 mg/dL and administered 10 units of Novolog insulin on 7/10/2024 at 1:43 PM to Resident #22.

There was no documentation on the July MAR Resident #22 had a blood glucose level taken or was administered Novolog insulin as ordered at 4:00 PM on 7/10/2024.

There was no documentation in the electronic medical record of Resident #22 that any additional interventions were taken for the elevated blood glucose reading on 7/10/2024 at 1:43 PM.

Med Aide #4, an agency employee, was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 revealed the following information. On the morning of 7/10/24 Med Aide #4 was assigned for the 7:00 AM to 7:00 PM shift to the hallway which Resident #22 resided. Nurse #4 relayed to Med

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hypoglycemia and/or hyperglycemia, were reported to the physician for appropriate intervention. This systemic modification will be accomplished by implementing the following measures:
Effective 09/09/2024, licensed nurse on duty will inform the resident; consult with the resident□s physician; and notify, the resident representative when there is; an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident□s physical, mental, or psychosocial status, a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), and/or a decision to transfer or discharge the resident from the facility, to including when resident□s blood glucose is excessive high or low blood glucose. This notification will be documented on each resident□s electronic medical records by the licensed nurse on duty.

Effective 09/09/2024, the facilities nursing administrative team, which includes the DON, ADON, Unit coordinators (#1, #2), and/or wound nurse, incorporated the process for reviewing clinical documentation for the last 24 hours and physician orders written in the last 24 hours, or from the last clinical meeting to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place Monday

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F 580	Continued From page 17 Aide #4 that she had already administered the morning medications to include insulin administration for Resident #22 on the 7:00 PM to 7:00 AM shift that ended on 7/10/2024. Med Aide #4 indicated she did not know what the blood glucose level of Resident #22 was at 8:00 AM. Med Aide #4 explained that she could not remember which licensed nurse was assisting her on 7/10/2024 at the 12:00 PM administration time but she thought it was Unit Manager #2. Med Aide #4 confirmed she did not administer Novolog insulin to Resident #22 on 7/10/2024 at 1:43 PM, because she was not allowed to administer insulin to residents under her scope of practice as a medication aide. According to Med Aide #4 on 7/10/2024 the blood glucose level for Resident #22 read as "HI" or above 400 mg/dL on the glucose monitor and Unit Manager #2 was made aware. (A reading of "HI" on a glucometer means the reading is above the level readable by the glucometer.) She revealed the MAR did not allow Novolog insulin to be checked off as administered unless an actual number was entered into the MAR for the blood glucose reading. Med Aide #4 stated she had to put in 400 mg/dL although the reading may have been over 400 mg/dL. Med Aide #4 indicated she was told by Unit Manager #2 the physician for Resident #22 was called and had ordered 12 units of Novolog insulin to be administered to Resident #22 and to keep checking the blood glucose level every hour. Med Aide #4 kept checking the blood glucose level every hour and reported to Unit Manager #2 the glucose reading was still registering as above 400 mg/dL. Med Aide #4 thought Unit Manager #2 was going to document everything and take care of the 4:00 PM scheduled Novolog insulin administration on 7/10/2024 because of the blood glucose readings that were over 400 mg/dL,	F 580	through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. The nursing administrative team will review the clinical documentation and physician orders written on Friday and/or Saturday on the next clinical meeting on the following Monday. Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident□s medical records, and inform a Nurse on duty immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including notifying the physician in a timely manner. 100% education of all licensed nurses to include full time, part time, and as needed licensed nurses will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Unit Coordinators (#1, #2). The emphasis of this education will be the importance of notifying physician and the responsible party in a timely manner for any change in condition, change of treatment/intervention, and/or incidents of sustained elevated blood glucose. This education will be completed by 9/09/2024, any licensed nurses not educated by 09/09/24 will not be allowed to work until educated. This education will also be	

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requiring a physician to be notified.

Unit Manager #2 was interviewed on 9/10/2024 at 8:21 AM. Unit Manager #2 revealed the following information. Unit Manager #2 did recall Med Aide #4 contacting her about an elevated glucose level for Resident #22 on 7/10/2024. Unit Manager #2 revealed she assessed Resident #22 and thought she was dehydrated but was arousable and able to drink fluids. Unit Manager #2 revealed she thought she sent a text to the physician for Resident #22 informing him of the elevated blood glucose levels on 7/10/2024 but, she could not recall specifically if she had done so.

There was no documentation on the July MAR Resident #22 had a blood glucose reading taken or was administered Novolog insulin as ordered at 8:00 AM on 7/11/2024.

The facility nursing schedule dated 7/11/2024 indicated Nurse #7 was assigned to the hallway for which Resident #22 resided for the 12 hour "day shift (7:00 AM to 7:00 PM)."

Nurse #7 was interviewed on 9/5/2024 at 2:37 PM. Nurse #7 stated she was an agency nurse who only worked at the facility on one occasion and that was 7/11/2024 for the 7:00 AM to 7:00 PM shift. Nurse #7 revealed when she arrived at the facility, she was not given login information for the electronic medical record system and was given paper MARs to work with for documentation of administration of the medications for residents on the hallway she was assigned. Nurse #7 revealed she was unable to recall what residents she took blood glucose levels for, but she would have documented calling the physician for an elevated blood glucose if that had been required

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implemented in new hire orientation.
Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses during the new hire orientation effective 09/09/2024.
Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/7/2024, Director of Nursing, and/or Assistant Director of Nursing, will monitor compliance with notification of changes to Physician and/or responsible party by reviewing the daily clinical meeting reports to ensure completion, timely notification to Physician and responsible party for any item identified to meet notification requirements. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained.
Effective 10/7/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

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F 580	Continued From page 19 of her. Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 11:47AM to Resident #22. Documentation on a physical therapy treatment encounter note for Resident #22 written by Physical Therapy Assistant (PTA) #1 on 7/11/2024 at 3:58 PM revealed, "PTA facilitated that [Resident #22] get [out of bed] for the purpose of attempting goals. [Resident #22] responded [by demonstrating] extreme lethargy, incoherent mumbling, [nonresponsive] pupils/eye movement to bright light. PTA attempted to have [Resident #22] sit [on edge of bed] with [Resident #22 [demonstrating] inability to arise from sleep/difficulty to hold head. Nursing [Med Aide #4], DON (Director of Nursing), [Physical Therapist/Occupational Therapist] notified regarding [Resident #22's] decrease in status. Continue [with plan of care.]" An interview was conducted with PTA #1 on 9/6/2024 at 4:45 PM. PTA #1 revealed the following information. PTA #1 stated she did not recall the exact time she went to see Resident #22 on 7/11/2024. PTA #1 confirmed she found Resident #22 in a nonresponsive condition on that day, so she went to the Med Aide on the hall, the interim DON, the Physical Therapist, and Occupational therapist to let them know of her concern for Resident #22. Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 4:51 PM.	F 580	Compliance date: 10/14/2024	

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F 580	Continued From page 20 Med Aide #4 was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 revealed the following information. Med Aide #4 confirmed she took the blood sugar readings for Resident #22 on 7/11/2024 at 11:47 AM and 4:51 PM. Med Aide #4 revealed that some of the blood glucose readings for Resident #22 were registering as HI or over 400 mg/dL while at least one of the readings she documented on the MAR on 7/11/2024 was actually 400 mg/dL. Med Aide #4 confirmed she told the licensed nurse who was assisting her on 7/11/2024 for the 12:00 PM and 4:00 PM administration time for the Novolog insulin, that the blood glucose levels were continuously registering as "HI." Med Aide #4 was told by the licensed nurse on 7/11/2024 the physician had been contacted and ordered for Resident #22 to be monitored. Med Aide #4 did not recall who the licensed nurse was. Med Aide #4 confirmed PTA #1 informed her of concerns of the lack of response from Resident #22. Med Aide #4 stated she did tell the licensed nurse of what PTA #1 had said. Med Aide #4 stated she informed Unit Manager #2 and sent a text message to the interim DON about the continued blood glucose readings of over 400 mg/dL for Resident #22. Med Aide #4 stated she got a text message back from the interim DON that she "would take care of it." Med Aide #4 stated that in report at the end of her shift on 7/10/24 and 7/11/24 she let Nurse #4 know Resident #22 was continually having blood glucose readings of over 400 mg/dL. Med Aide #4 indicated Nurse #4 did not seem to care, telling her that on the shift, 7:00 PM to 7:00 AM, when Nurse #4 worked, the blood glucose readings for Resident #22 were in the 200's mg/dL. Med Aide #4 stated, "It just didn't make any sense to me but only the nurses can call the	F 580		

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F 580	Continued From page 21 doctor." Documentation in the physician orders revealed an order dated 7/11/2024 at 7:00 PM for Resident #22 to be administered ten units of Humalog insulin solution to be injected subcutaneously one time only for a blood glucose exceeding 400 mg/dL and contact the physician in two hours. Humalog insulin is a fast-acting insulin which is absorbed quickly and starts working in about 15 minutes after injection to lower blood glucose levels. There was no documentation on the July MAR that the order for Humalog insulin was administered to Resident #22 on 7/11/2024 after 7:00 PM. Documentation in the physician orders revealed an order dated 7/11/2024 at 9:00 PM for Resident #22 to be administered ten units of Novolog insulin solution subcutaneously one time for blood glucose exceeding 400 mg/dL and contact the physician in two hours. There was no documentation on the July MAR that the one-time order for Novolog insulin was ever administered to Resident #22 on 7/11/2024 after 7:00 PM. Documentation in the nursing notes for Resident #22 dated 7/12/2024 at 9:48 AM by Nurse #4 revealed, "Physician contacted due to blood glucose exceeding 400 (mg/dL) and order received from physician to administer 10 [units] of Humalog or Novolog and report back after 2 hours. After 2 hours, resident blood [glucose] reading still exceeded 400 (mg/dL) and physician	F 580		

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F 580	Continued From page 22 made aware of results. Family arrived and RP (Responsible Party) requested for resident to be sent to [emergency room] for evaluation. Physician made aware and order received to send resident to [emergency room]. DON made aware." An interview was conducted with Nurse #4 on 9/5/2024 at 6:04 PM. Nurse #4 relayed the following information and timeline of events for Resident #22 on the evening of 7/11/2024. Nurse #4 started her 7:00 PM to 7:00 AM shift at 7:00 PM on 7/11/2024. Nurse #4 received the information in a nursing report from Med Aide #4 that the blood glucose level of Resident #22 was above 400 mg/dL on the 4:00 PM medication pass. Nurse #4 denied she had any knowledge of the blood glucose level of Resident #22 being at or above 400 for several shifts. Nurse #4 stated she assessed Resident #22 and took her vital signs at the start of her shift. Nurse #4 revealed the blood glucose level of Resident #22 was registering as High or over 400 on the glucometer, a device to measure blood glucose levels. Nurse #4 revealed the vital signs of Resident #22 were fine, so she called the on-call physician. Nurse #4 stated she received an order from the physician to administer 10 units of fast acting insulin to Resident #22 and call the physician back in two hours. Nurse #4 stated she went back to check on Resident #22 again at 9:00 PM and all her vital signs were fine. Resident #22 did not have a temperature, elevated blood pressure, or an elevated heart rate. Nurse #4 stated her blood glucose level was still registering as High or above 400 mg/dL on the glucometer. Nurse #4 was adamant Resident #22 was fine and was responsive. Nurse #4 related that when she pricked the finger of	F 580		

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F 580	Continued From page 23 Resident #22 with the lancet, the resident looked at her and rolled her eyes. Nurse #4 stated the family of Resident #22 arrived at the facility stating they received a phone call from an unknown caller telling them something was wrong with Resident #22, and she needed to be sent to the emergency room. The family of Resident #22 looked at Resident #22 and demanded she be sent to the emergency room. Nurse #4 stated she did not know who called the family because the breathing and vital signs for Resident #22 were normal. Nurse #4 reported she was about ready to call the physician because of the elevated blood glucose reading, so she called the physician, and the physician agreed Resident #22 could be sent out per the family wishes. An interview was conducted with the responsible party (RP) for Resident #22 on 9/3/2024 at 3:42 PM and the following information was provided. On 7/8/2024 the RP checked on Resident #22 before going out of town and she was okay. The RP heard nothing all week from the facility. On 7/11/24 around 7:30 PM to 8:00 PM she saw she had several missed calls on her phone. She then picked up on the next one. It was from a private number. The person on the phone did not identify themselves but told the RP, " You need to come now and check on your mother. It is an emergency. She needs to be sent out." The RP did not know what was going on because the facility did not notify her that Resident #22 was sick. The RP called another family member who was local to the facility and asked him to go to the facility to see Resident #22. The family member arrived at the facility around 8:30 to 8:45 PM to find Resident #22 was not responding. Nurse #4 walked into the room with a blood glucose monitor and said the doctor ordered Resident #22	F 580		

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to receive 10 units of insulin, to monitor her blood glucose level, and call the doctor back in two hours. Since Resident #22 was not responding the family member insisted that Resident #22 be sent to the emergency room and finally Nurse #4 called emergency medical services (EMS). The RP talked to the (former) Administrator about her concerns and the (former) Administrator informed the RP that the facility had learned that a physical therapy staff member had noted a change in the resident earlier that day (7/11/2024). The (former) Administrator maintained that they did not have to let the family know if Resident #22 had elevated blood glucose levels, which did not make sense to her. If she had known that Resident #22's blood glucose levels were running high for several days she would have wanted her sent to the hospital to be checked.

An interview was conducted with the interim DON on 9/5/2024 at 1:58 PM. The interim DON stated she was not made aware of any concerns with the blood glucose levels of Resident #22 until the RP called her on the evening of 7/11/2024 at approximately 8:00 PM or 8:30 PM. The interim DON was told by the RP of a phone call she received from a facility staff member telling her Resident #22 was very ill and needed to be sent to the hospital. The interim DON relayed she called Nurse #4 and was told Resident #22 was still at the facility and was fine. The interim DON further revealed Nurse #4 had explained the following interventions for Resident #22. An assessment had been completed by Nurse #4 revealing an elevated blood glucose level, lethargy, vital signs were fine, the physician was called for orders, and Resident #22 was responsive. The interim DON stated she knew the blood glucose level of Resident #22 was high

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in the moment on the evening of 7/11/2024 but she was not aware the blood glucose level had been high over several shifts.

Documentation on an Emergency Medical Services (EMS) report dated 7/11/2024 revealed 911 was called at 9:17 PM and arrived at room of Resident #22 at 9:37 PM. The following information was revealed in the EMS report. Upon arriving at the scene, the facility staff stated Resident #22 had been having an elevated blood glucose level all day and had been alert but not acting like herself. The facility staff also told EMS they had been giving Resident #22 insulin as instructed by the resident's physician with no changes in the reading level of HI on the glucose monitor. EMS noted Resident #22 had a glucose reading of High on their glucose monitor as well. EMS documented Resident #22 as having a heart rate of 140 with respirations in the 40s. Once in the ambulance, Resident #22 remained unresponsive.

Documentation on a hospital record dated for a 7/11/2024 admission revealed Resident #22 was diagnosed with sepsis, hyperglycemia, altered mental status, acute renal failure, dehydration, and a urinary tract infection in the emergency room.

An interview was conducted with Medical Doctor (MD) #2, the physician for Resident #22, on 9/9/2024 at 1:12 PM. MD #22 stated he could not recall if he was notified of the elevated blood glucose levels of Resident #22 on 7/9/2024, 7/10/2024, or 7/11/2024. MD #2 explained that if he had been notified of elevated blood glucose levels for Resident #22 during normal business hours, he would have ordered a change in the

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amount of fast-acting insulin to be administered and requested a call back if there was no change after continuous monitoring of the resident. MD #2 indicated that if those orders did not exist on 7/10/2024 or 7/11/2024 during the day shift then it was likely he was not notified. MD #2 stated he did not recall receiving a phone call on the evening of 7/11/2024 from Nurse #4, but he received phone calls of that type routinely making it difficult to recall a specific phone call of that type for a resident. MD #2 stated that a blood glucose level of 400 mg/dL was "not good," but having a blood glucose level of 400 mg/dL was an isolated event for this resident making it likely an underlying medical condition was occurring for which he would have had to figure out.

On 9/9/24 at 5:04 PM the facility Administrator and Corporate Nurse Consultant were notified of Immediate Jeopardy.

The facility provided the following immediate jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #22 was admitted to the facility on 08/02/2023 and discharged on 07/11/2024. Between the original admission and discharge, she was readmitted on 06/21/2024. The most recent readmission, she was readmitted with diagnoses that included: Type 2 diabetes with diabetic retinopathy without macular edema (a complication of diabetes that can cause vision loss and blindness), schizoaffective disorder, dementia, chronic embolism (long-term condition where one or more blood clots block the

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pulmonary arteries), and thrombosis of distal lower extremity (a blood clot condition that forms within the deep veins, usually of the leg, but can occur in the arms).

Review of Resident #22's Medication Administration Records (MAR), indicates; on 7/10/24 at 1:43pm the medication aide (MA #4) notified Unit Manager #2 that Resident #22 had blood glucose levels registering over 400. No evidence that the physician was notified. Resident #22's MAR indicates that Resident #22 received 10 units of Novolog insulin at 1:43pm. Further review of Resident #22's MAR indicates; on 7/11/2024, at 11:47 am, Resident #22's blood glucose was documented to be 400. No evidence that the physician was notified, and 10 units of fast-acting insulin were administered.

Review of the Physical Therapy Assistant documentation on 7/11/24 at 3:38 PM indicated the resident was non-responsive, and the Director of Nursing was notified. No documentation of actions taken. The Director of Nursing who was informed is no longer working at the facility. No evidence that the physician was notified.

On 7/11/24 at 4:51pm blood glucose documented by MA #4 to be 400. The MAR indicates Resident #22 received 10 units of Novolog insulin. No evidence that the physician was notified, no indication that anything else was done.

Review of progress notes documented on 7/12/2024 (late entry for 7/11/2024), in Resident #22's medical records indicate (in part); Nurse #4 contacted physician due to Resident #22's blood glucose exceeding 400. An order was received from the physician to administer ten units of

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F 580	Continued From page 28 Humalog or Novolog and report back after 2 hours. After two hours, Resident #22's blood glucose reading still exceeded 400 and the physician made aware of results, the note added. Resident #22's family arrived and requested that Resident #22 to be sent to the hospital for evaluation. The physician made aware, and the order received to send resident to hospital, documentation concluded. A phone interview was conducted on 09/07/2024 by the Assistant Director of Nursing. Nurse #4 indicated; she contacted the physician around 7:10pm on 7/11/2024 due to Resident #22's blood glucose exceeding 400. Nurse #4 added she received an order to administer ten units of Humalog or Novolog and report back after 2 hours. Nurse #4 indicated that she recalled administering 10 units of Novolog to Resident #22 per physician order. Nurse #4 further added that, at approximately 9:00pm, she rechecked Resident #22's blood glucose, the reading still exceeded 400. She added the physician was made aware of the results at approximately 9:03pm. Per Nurse #4, Resident #22's family arrived at approximately 9:05pm and requested for Resident #22 be sent to the hospital. The physician was made aware of the request at approximately 9:10pm, and the order was received to send the resident to hospital, Nurse # 4 contacted EMS at 9:17pm, interview concluded. EMS arrived on scene at 9:32pm. Resident #22 was still non-responsive when EMS arrived. Per EMS report, Resident #22 was found with an elevated heart rate of 140, respirations in the 40s, and with a continued reading of a blood sugar in excess of 400 at time of transport. Resident #22 was sent to the hospital for further evaluation and treatment, Resident #22 left the facility at	F 580		

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approximately 9:53pm. Resident #22 is no longer in the facility. No other actions taken.

The Governing body led by the Vice President of Operation, the facility Administrator, Regional Director of Clinical Services, and Director of Nursing conducted the root cause analysis on 09/06/2024, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences.

For Resident #22, the Root Cause Analysis (RCA) identified the alleged noncompliance resulted from the failure of the facility employee (Nurse # 4) to follow the professional standard of practice to inform the attending physician of the elevated blood glucose levels that were sustained over a two-day time frame and over multiple shifts for Resident #22.

The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.

Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention and/or notification to the physician. The clinical assessment focused on resident's vital signs to include, blood pressure

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reading, pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated.

100% audit of all current resident's blood glucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a resident with episodes of hypoglycemia and/or hyperglycemia to ensure notification to the attending physician was made. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Effective 09/07/2024, facility employees will ensure significant changes, to include hypoglycemia and/or hyperglycemia, were reported to the physician for appropriate intervention. This systemic modification will be accomplished by implementing the following measures:

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Effective 09/09/2024, licensed nurse on duty will inform the resident; consult with the resident's physician; and notify, the resident representative when there is; an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), and/or a decision to transfer or discharge the resident from the facility, to including when resident's blood glucose is excessive high or low blood glucose. This notification will be documented on each resident's electronic medical records by the licensed nurse on duty.

Effective 09/09/2024, the facilities nursing administrative team, which includes the DON, ADON, Unit coordinators (#1, #2), and/or wound nurse, incorporated the process for reviewing clinical documentation for the last 24 hours and physician orders written in the last 24 hours, or from the last clinical meeting to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. The nursing administrative team will review the clinical documentation and physician orders written on Friday and/or Saturday on the next clinical meeting on the following Monday.

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Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident's medical records, and inform a Nurse on duty immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including notifying the physician in a timely manner.

100% education of all licensed nurses to include full time, part time, and as needed licensed nurses will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Unit Coordinators (#1, #2). The emphasis of this education will be the importance of notifying physician and the responsible party in a timely manner for any change in condition, change of treatment/intervention, and/or incidents of sustained elevated blood glucose. This education will be completed by 9/09/2024, any licensed nurses not educated by 09/09/24 will not be allowed to work until educated. This education will also be implemented in new hire orientation. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses during the new hire orientation effective 09/09/2024.

Alleged immediate jeopardy removal date: 09/09/2024.

On 9/12/24 the following was done to validate the

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F 580	Continued From page 33 facility's immediate jeopardy removal plan: Review of records revealed documentation confirming the completion of audits and in-service training per the facility's removal plan. A review of staffing schedules revealed that there was a designation on the schedule noting which licensed nurse was assigned to cover for any Medication Aide so that physician notification could take place when needed. Beginning at 9:45 AM on 9/12/24 multiple staff members were interviewed regarding in-service training the facility had provided. Staff were able to report details of their training and validated they attended. Staff were also interviewed regarding whether they had witnessed any resident go without medical care during the past week for failure of assessment and notification of the physician of changes. There were no reports of a lack of medical care for acutely ill residents due to a lack of physician notification. A random interview was conducted on 9/12/24 at 1:35 PM with an alert and oriented diabetic resident regarding her medical care. The resident reported no problems with her diabetic care due to staff not communicating with the physician. The facility's immediate jeopardy removal, date of 9/9/24, was validated.	F 580		
F 584 SS=D	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	F 584		10/14/24

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F 584	Continued From page 34 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 584	F584	

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interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one (Resident # 19) of four residents reviewed for a homelike and clean environment. The findings included:

Resident # 19 was admitted to the facility on 12/5/23.

Review of Resident # 19's quarterly Minimum Data Set assessment, dated 8/2/24, revealed the resident was assessed to be cognitively intact.

A nursing noted on 8/26/24 noted that Resident # 19 was notified of a room change that would occur. The resident's record indicated the room change occurred on 8/27/24.

Resident # 19 was interviewed on 8/29/24 at 9:15 AM and reported the following information. She had been told on 8/26/24 (Monday) that she had to move to a new room for insurance reasons. When they moved her on 8/27/24 she had to wait in the hall for 20 minutes because the new room was not cleaned. When they did move her completely in the room, she found the entire room had not been cleaned. There had been lots of medical equipment left in her new room's bathroom and it did not belong to her roommate. During the interview, Resident # 19 asked the surveyor to open her bathroom door and observe. Resident # 19 pointed to medical items such as oxygen equipment and a bedpan located in wheelchairs which did not belong to her or to her roommate.

On 8/29/24 at 9:30 AM Unit Manager # 1 was asked to view Resident # 19's bathroom and all

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Corrective actions accomplished for those residents found to be affected by the deficient practice:
Resident #19s room was inspected and cleaned by the Housekeeping Manager on 10/2/2024.
Identification of other residents having the potential to be affected by the same deficient practice:
The Director of housekeeping will complete 100% audit of all resident rooms to ensure that they are clean and appropriate, and if they are not clean, they will be cleaned immediately. This audit was completed on 10/3/2024. Findings of this audit is documented on housekeeping audit tool located in the facility compliance binder.
Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:
Effective 10/07/2024, the facility will ensure residents have a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely, including providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; these systemic changes will be accomplished by implementing the following measures:
Effective 10/07/2024, the need for a room change will be discussed in the daily stand-up meeting that takes place Monday through Fridays by the Admission coordinator and/or designated person.

Effective 10/07/2024, following the room

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F 584	Continued From page 36 the medical items located there. The Unit Manager reported she was not aware why the items had not been cleaned out before the resident was moved into the new room, and this should have occurred. The Housekeeping Director was interviewed on 8/29/24 at 9:35 AM and reported the following information. She had not been at the facility on the day Resident # 19 was moved. It was her expectation that the housekeeping staff remove all used medical equipment that did not belong in the room and sanitize the entire room, which included the bathroom, before a resident was moved into a new room.	F 584	change need discussed in the daily meeting, the facility Housekeeping manager and/or Admission coordinator will visit the resident room (where resident will be moved to), and ensure the room is clean and sanitary before room move. This systemic changes will be documented on Quality Control Inspection (QCI) form. Assistant Administrator will complete an education to the facility social workers, Admission coordinator, and housekeeping manager. The emphasis of this education will be the importance of discussing room changes in the daily stand-up meeting. The education also emphasized the importance of housekeeping manager to inspect the room before the room changes take place. This education will be completed by 10/14/2024. This education will also be implemented in new hire orientation for social workers, Admission coordinators and housekeeping manager. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/07/2024, the Administrator/Assistant Administrator will review all room moves that were completed in the last 24 hours or from the last stand-up meeting to ensure that a room was inspected before the move. This monitoring process will be conducted twice weekly for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. The findings of this process will be submitted to QAPI for review and recommendation by the Administrator	

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F 584	Continued From page 37	F 584	and/or Assistant administrator monthly for three months or until the pattern of compliance is maintained. Completion date: 10/14/2024	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, family interview, and physician interview the facility failed to protect a resident's right to be free from neglect when they failed to comprehensively assess and effectively monitor a resident with blood glucose levels registering over 400 milligrams per deciliter (mg/dL) (normal blood sugar levels are considered to be between 70mg/dL to 100 mg/dL) over two days, accurately notify the physician of the resident's medical status to ensure necessary care and services were implemented to treat the resident, and to identify the seriousness of the resident's change in medical status and the need to immediately	F 600	F600 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #22 no longer in the facility, no other actions taken for resident #22 Identification of other residents having the potential to be affected by the same deficient practice: Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other	10/14/24

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F 600	Continued From page 38 initiate emergency medical services (EMS) when the resident was identified as nonresponsive. EMS was not notified until hours after the resident was first observed as nonresponsive by a physical therapy staff member. Resident #22 was assessed by EMS with an elevated heart rate of 140 beats per minute (bpm) (a typical resting heart rate for adults is between 60 and 100 bpm), respirations in the 40s breaths per minute (a normal respiratory rate is between 12 and 20 breaths per minute), and with a continued reading of a blood glucose level more than 400 mg/dL at time of transport by EMS. An Emergency Department (ED) physician assessment indicated Resident #22 was diagnosed with sepsis (a life-threatening complication of an infection) briefly explain and hyperglycemia. (Hyperglycemia is a medical condition in which the body's blood glucose level is higher than normal. High blood glucose happens when the body has too little insulin or when the body can't use insulin properly.) This was for one (Resident #22) of five residents reviewed for neglect. Immediate jeopardy began on 7/10/2024 when staff neglected to provide the necessary care and services to Resident #22 when she was identified as having a blood glucose reading of over 400 mg/dL. Immediate Jeopardy was removed on 9/9/2024 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. Findings included: Resident #22 was originally admitted to the facility	F 600	resident with the change condition that require medical attention. The clinical assessment focused on resident□s vital signs to include, blood pressure reading, pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated. 100% audit of all current resident□s blood glucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a resident with episodes of hypoglycemia and/or hyperglycemia that was not addressed appropriately in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents□ choices. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered. If the identified issues indicate neglect, that were not previously reported to the state, law enforcement, and Adult protective services (APS), the facility Administrator will protect all residents by immediately	

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on 8/2/2023 with multiple diagnoses some of which included dementia, type 2 diabetes mellitus, schizoaffective disorder, major depressive disorder, and hypertension. Resident #22 was readmitted to the facility on 6/21/24 after a hospitalization for the diagnoses of sepsis, urinary tract infection, and hydronephrosis. (Hydronephrosis is a medical condition characterized by excess fluid in a kidney due to blockage in the tube that connects the kidney to the bladder.)

Documentation on a quarterly Minimum Data Set assessment dated 6/24/2024 revealed Resident #22 was assessed as having adequate hearing and vision with clear speech. Documentation on the same assessment indicated Resident #22 was usually understood and usually had the ability to understand others. Resident #22 was coded as having the diagnosis of type 2 diabetes mellitus and received insulin injections for 7 days of the assessment period.

Documentation on the care plan initiated on 6/22/2024 revealed a care plan description of Resident #22's risk for hypo/hyperglycemia and a diagnosis of diabetic retinopathy relative to a diagnosis of diabetes mellitus. One of the interventions was to observe signs and symptoms of hypo/hyperglycemia such as sweating, tremor, pallor, nervousness, headache, double vision, confusion, and or lack of coordination. Additional interventions were to perform blood glucose monitoring and medication/insulin as ordered.

Documentation in a physician order dated 6/22/2024 revealed Resident #22 was ordered to receive Novolog insulin solution to be injected subcutaneously (applied under the skin) three

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suspending the alleged perpetrator, report the identified issue of neglect to the State agency, law enforcement, and APS within two hours of identification and initiate thorough investigation, immediately. The facility Administrator will report the result of the investigation to the State agency within five working days.

Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:

Effective 09/09/2024, facility will ensure all residents remain free from abuse and neglect by following the facility company abuse prohibition policy and providing care in accordance with standard of practice and notifying the physician in a timely manner for any changes in resident�s condition.
Effective 09/07/2024, facility employees will ensure residents received necessary care to include assessing, monitoring, addressing a change in condition, identify the seriousness of a change in condition, and recognize the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents� choices. This systemic modification will be accomplished by implementing the following measures:
Effective 09/07/2024, licensed nurses will oversee care and services for each resident in the facility. A licensed nurse will be informed at the beginning of the shift, through the daily schedule, of his/her

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times day at 8:00 AM, 12:00 PM, and 4:00 PM per the following sliding scale: If the blood glucose level was 201 to 250 administer 4 units; 251 to 300 administer 6 units; 301 to 350 administer 8 units; 351 to 400 administer 10 units; greater than 400 call the physician. Novolog is a fast-acting insulin used to treat high blood glucose for people with diabetes.

Documentation in a physician order dated 6/22/2024 revealed Resident #22 was ordered to receive 5 units of Semglee insulin solution to be injected subcutaneously one time a day at 8:00 PM for hyperglycemia. Semglee is a long-acting insulin used to treat high blood glucose levels for people with diabetes.

Documentation on the July Medication Administration Record (MAR) for Resident #22 revealed on 7/9/2024 the blood glucose level was 399 and Medication Aide (Med Aide) #5 administered ten units of insulin at 6:22 PM.

Med Aide #5, an agency employee, was interviewed on 9/5/2024 at 1:08 PM and revealed the following information. Med Aide #5 confirmed she did take the blood glucose reading of 399 on 7/9/2024 and that she did not administer insulin to Resident #22. Med Aide #5 did not recall who the licensed nurse was who was assigned to help her perform medication administration tasks out of her scope of practice on 7/9/2024. Med Aide #5 explained when she put the blood glucose reading into the electronic MAR, the administration of the insulin would also incorrectly go under her name. Med Aide #5 indicated she had to trust that the licensed nurse, to whom she reported the blood glucose level of Resident #22, would administer the correct insulin dose,

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responsibility to oversee certified medication aide(s) if any.

Effective 09/07/24, Director of Nursing, Assistant Director of Nursing, Unit Coordinator (#1 or #2), Weekend Supervisor, and/or Scheduling Coordinator will be responsible to update daily schedule for nursing staff (licensed nurses, medication aides, and certified nursing aides). The daily schedule will inform each nursing staff of their assignment and responsibilities to include responsibility for licensed nurses to oversee medication aides (if any).

The Facility Administrator will educate Director of Nursing, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator. The education focused on the importance of ensuring a daily nursing schedule is completed and indicate the responsibility of each nursing staff to include the responsibilities of the licensed nurse to oversee the medication aides. This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24 will not be allowed to work until educated. The Director of Nursing will complete this education for any newly hired, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator during the orientation process effective 9/8/2024.

Effective 09/07/2024 the assigned licensed nurse will be responsible to

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F 600	Continued From page 41 document the administration, and notify a physician of any concerns if needed. Documentation on the July MAR revealed Nurse #4 administered Semglee insulin as ordered to Resident #22 on 7/9/2024 at 8: 24 PM. There was no documentation on the July MAR Resident #22 had a blood glucose level taken or received Novolog insulin as ordered at 8:00 AM on 7/10/2024. Med Aide #4, an agency employee, was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 revealed the following information. On the morning of 7/10/24 she was assigned for the 7:00 AM to 7:00 PM shift to the hallway which Resident #22 resided. Med Aide #4 was told Nurse #4 took care of administering medications for several people during the 7:00 PM to 7:00 AM shift ending on 7/10/2024. Resident #22 was one of those people who Nurse #4 told Med Aide #4 she had already administered the morning medications to. Med Aide #4 stated she expected Nurse #4 to document on the MAR the medications she was told had already been administered as an explanation for why there was no documentation of the Novolog insulin for Resident #22 at 8:00 AM on 7/10/2024. Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered 10 units of Novolog insulin on 7/10/2024 at 1:43 PM to Resident #22, one hour and 43 minutes after the scheduled administration time. There was no documentation on the July MAR Resident #22 had a blood glucose level taken or	F 600	provide necessary care to include assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents□ choices for their assigned residents, and/or those assigned to the medication aide under the nurse□s supervision. Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident□s medical records, and inform a Nurse on duty immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services, and notifying the attending physician in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents□ choices. Effective 09/07/2024, facility licensed nurses on duty will administer medication related to hypoglycemia and/or hyperglycemia, including glucagon for low	

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was administered Novolog insulin as ordered at 4:00 PM on 7/10/2024.

Med Aide #4, an agency employee, was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 relayed the following information. Med Aide #4 explained that she could not remember which licensed nurse was assisting her on 7/10/2024 and confirmed she did not administer Novolog insulin to Resident #22 on 7/10/2024 at 1:43 PM. Med Aide #4 thought the licensed nurse, assisting her on 7/10/24, was Unit Manager #2. On 7/10/2024 the blood glucose level for Resident #22 read as "HI" or above 400 on the glucose monitor. (A reading of "HI" on a glucometer means the reading is above the level readable by the glucometer.) The licensed nurse who was assisting Med Aide #4 was told the blood glucose monitor was reading above 400 and the physician needed to be called. The licensed nurse told Med Aide #4 the physician ordered 12 units of Novolog insulin to be administered to Resident #22 and to keep checking the blood glucose level every hour. Med Aide #4 kept checking the blood glucose level every hour and reported to the licensed nurse the reading was still registering as above 400 mg/dL. Med Aide #4 thought the licensed nurse was going to document everything and take care of the 4:00 PM scheduled Novolog insulin administration on 7/10/2024 because of the blood glucose readings that were over 400 mg/dL, requiring a physician to be notified.

Unit Manager #2 was interviewed on 9/10/2024 at 8:21 AM. Unit Manager #2 revealed the following information. Unit Manager #2 did recall Med Aide #4 contacting her about an elevated glucose level for Resident #22 on 7/10/2024. Unit Manager #2 revealed she assessed Resident #22 and thought

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blood sugar, and/or insulin for high blood glucose, based on physician orders and document the administration of such medication in each resident□s clinical record.
Effective 09/07/2024, residents with blood glucose over 400 will receive 10 units of fast acting insulin, (Humalog or Novolog), blood glucose will be rechecked within 30 minutes, or per physician order, after the administration of insulin, if blood glucose remains over 400, resident□s physician will be notified for further evaluation and/or treatment. This protocol is implemented effective 09/07/2024.
100% education of all current staff to include full-time, part-time, and as needed employees will be completed by the Administrator, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator. The emphasis of this education includes but is not limited to, the importance of providing care to all residents in the facility. The education also focused on facility abuse prohibition policy and procedures to include prevention of resident neglect by following physician orders related to administration of insulin for residents with high blood glucose and notifying physician in accordance with physician orders and when there is an instance of sustained elevated blood glucose levels over a period of time. This education also emphasized the definition of neglect as the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 600	Continued From page 43 she was dehydrated but was arousable and able to drink fluids. Unit Manager #2 stated she was very busy on 7/10/24, in addition to being the unit manager, the only registered nurse in the building, doing wound care, and admitting multiple residents, leaving her with little time for adequate coverage of the Med Aides in the building. Unit Manager #2 revealed she thought she sent a text to the physician for Resident #22 informing him of the elevated blood glucose levels on 7/10/2024. Unit Manager #2 stated she trusted the judgement of Med Aide #4 and felt she communicated effectively if she needed any assistance. Unit Manager #2 could not recall specifically what interventions were put in place on 7/10/2024 other than administration of insulin and fluids but would trust the recollections of Med Aide #4. Unit Manager #2 revealed she kept a small notebook with notes on which residents she had to go back and complete documentation on as a late entry. Unit Manager #2 thought perhaps Resident #22 having elevated blood sugars was one of those residents and she forgot to go back and document. Documentation on the July MAR revealed Nurse #4 administered Semglee insulin as ordered to Resident #22 on 7/10/2024 at 10:56 PM. There was no documentation in the electronic medical record of Resident #22 that any additional interventions were taken for the elevated blood glucose reading on 7/10/2024. There was no documentation on the July MAR Resident #22 had a blood glucose level taken or was administered Novolog insulin as ordered at 8:00 AM on 7/11/2024.	F 600	This education will be completed by 09/08/2024. Any staff members not educated by 09/09/2024, will not be allowed to work until educated. The Administrator, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will monitor and track the completion of this education and provide it for any newly hired employee during the new hire orientation, and annually. 100% education of all licensed nurses and Medication aides, to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to: 1. The importance of administering medication to include insulin, glucagon, and other medications per physician order. 2. The importance of ensuring each resident is assigned to a licensed nurse to oversee his/her care including provision for assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. 3. The importance for each medication aide to be aware of their assigned licensed nurse at the beginning of their shift (through the daily schedule that will	

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The facility nursing schedule dated 7/11/2024 indicated Nurse #7 was assigned to the hallway for which Resident #22 resided for the 12 hour "day shift (7:00 AM to 7:00 PM)."

Nurse #7 was interviewed on 9/5/2024 at 2:37 PM. Nurse #7 stated she was an agency nurse who only worked at the facility on one occasion and that was 7/11/2024. Nurse #7 stated she did not recall what hall she was assigned to. Nurse #7 stated when she arrived at 7:00 AM on 7/11/2024, the scheduler handed her a stack of paper MARs and told her to go to the hall to begin the medication pass. Nurse #7 explained she was told she would not have access to the electronic medical record system. Nurse #7 revealed it was "chaos", but she stayed. Nurse #7 further explained that at 2:30 PM she was approached by the Interim Director of Nursing (DON) with the electronic medical record system login information she needed and another stack of papers for a new admission she was expected to process. Nurse #7 said she handed the new admission paperwork back to the Interim DON and told her she wasn't doing it. Nurse #7 revealed she had never returned to the facility.

Med Aide #4 was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 stated she was assigned on 7/11/2024 for the 7:00 AM to 7:00 PM shift to another hall next to the hall which Resident #22 resided. Med Aide #4 revealed everything was "a mess" on the hallway which Resident #22 resided because there was an agency nurse (Nurse #7) who was trying to figure out the paper MAR and she was not giving medications. Med Aide #4 revealed the agency nurse (Nurse #7) left and was put on the do not return list.

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indicate the nurse who is responsible to oversee them)
4. The implementation of hyperglycemia protocol includes administration of fast acting insulin and rechecking blood sugar within 30 minutes and notifying physician for any other orders.
5. The importance of calling 911 for medical emergencies that require medical attention at the acute care center. (The education emphasized that any staff member can call 911 when indicated.)
6. The importance of documenting blood glucose findings in resident�s medical records.
7. For medication aides, the education also covered the importance to report to the charge nurse immediately any blood glucose level less than 60, greater than 200 or based on the physician order.
This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will

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Documentation on the July MAR revealed Med Aide #4 obtained a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 11:47AM to Resident #22.

Documentation on a physical therapy treatment encounter note for Resident #22 written by Physical Therapy Assistant (PTA) #1 on 7/11/2024 at 3:58 PM revealed, "PTA facilitated that [Resident #22] get [out of bed] for the purpose of attempting goals. [Resident #22] responded [by demonstrating] extreme lethargy, incoherent mumbling, [nonresponsive] pupils/eye movement to bright light. PTA attempted to have [Resident #22] sit [on edge of bed] with [Resident #22 [demonstrating] inability to arise from sleep/difficulty to hold head. Nursing [Med Aide #4], DON, [Physical Therapist/Occupational Therapist] notified regarding [Resident #22's] decrease in status. Continue [with plan of care.]"

An interview was conducted with PTA #1 on 9/6/2024 at 4:45 PM. PTA #1 revealed the following information. PTA #1 stated she did not recall the exact time she went to see Resident #22 on 7/11/2024. PTA #1 confirmed she found Resident #22 in a nonresponsive condition on that day, so she went to the Med Aide on the hall, the interim DON, the Physical Therapist, and Occupational therapist to let them know of her concern for Resident #22.

Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 4:51 PM.

Med Aide #4 was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 confirmed she took the blood

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complete the monitoring process to attain and maintain compliance related to prevention of abuse and/or neglect. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for blood glucose monitoring to ensure licensed nurses reviewed blood glucose outside the physician ordered parameters and address elevated and/or blood glucose reading per physician orders. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON, ADON and/or Unit Coordinator #1 or #2 promptly. This monitoring process will be documented on a blood glucose monitoring tool located in the facility compliance binder.
Effective 10/07/2024, facility Administrator and/or Assistant administrator will observe five randomly selected residents to ensure care is provided timely and no neglect is noted. Any negative findings will be addressed promptly by the Administrator, and/or Assistant Administrator. This monitoring process will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained.
Effective 10/07/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring

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F 600	Continued From page 46 glucose readings for Resident #22 on 7/11/2024 at 11:47 AM and 4:51 PM. Med Aide #4 revealed that some of the blood glucose readings for Resident #22 were actually registering as HI or over 400 mg/dL while at least one of the readings she documented on the MAR on 7/11/2024 was actually 400 mg/dL. Med Aide #4 revealed the MAR did not allow Novolog insulin to be checked off as administered unless an actual number was entered into the MAR for the blood glucose reading. Med Aide #4 stated she had to put in 400 mg/dL although the reading may have been over 400 mg/dL. Med Aide #4 confirmed she told the licensed nurse who was assisting her on 7/11/2024 for the 12:00 PM and 4:00 PM administration time for the Novolog insulin, that the blood glucose levels were continuously HI. Med Aide #4 explained the licensed nurses were going into the MAR after she documented the blood glucose reading and using her login credentials to document the administration of insulin. Med Aide #4 was told by the licensed nurse on 7/11/2024 the physician had been contacted and ordered for Resident #22 to be monitored. Med Aide #4 did not recall who the licensed nurse was. Med Aide #4 confirmed PTA #1 informed her of concerns of the lack of response from Resident #22. Med Aide #4 stated she did tell the licensed nurse of what PTA #1 had said. Med Aide #4 stated she informed Unit Manager #2 and sent a text message to the interim DON about the continued blood glucose readings of over 400 mg/dL for Resident #22. Med Aide #4 stated she got a text message back from the interim DON that she "would take care of it." Med Aide #4 stated that in report at the end of her shift on 7/10/24 and 7/11/24 she let Nurse #4 know Resident #22 was continually having blood glucose readings of over 400 mg/dL. Med	F 600	or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	

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F 600	Continued From page 47 Aide #4 indicated Nurse #4 did not seem to care, telling her that on the shift, 7:00 PM to 7:00 AM, when Nurse #4 worked, the blood glucose readings for Resident #22 were in the 200's mg/dL. Med Aide #4 stated, "It just didn't make any sense to me but only the nurses can call the doctor." An interview was conducted with the responsible party (RP) for Resident #22 on 9/3/2024 at 3:42 PM and the following information was provided. On 7/8/2024 the RP checked on Resident #22 before going out of town and she was okay. The RP heard nothing all week from the facility. On 7/11/24 around 7:30 PM to 8:00 PM she saw she had several missed calls on her phone. She then picked up on the next one. It was from a private number. The person on the phone did not identify themselves but told the RP, " You need to come now and check on your mother. It is an emergency. She needs to be sent out." The RP did not know what was going on because the facility did not notify her that Resident #22 was sick. The RP called another family member who was local to the facility and asked him to go to the facility to see Resident #22. The family member arrived at the facility around 8:30 to 8:45 PM to find Resident #22 was not responding. Nurse #4 walked into the room with a blood glucose monitor and said the doctor ordered Resident #22 to receive insulin, to monitor her blood glucose level, and call the doctor back in two hours. Since Resident #22 was not responding the family member insisted that Resident #22 be sent to the emergency room and finally Nurse #4 called emergency medical services (EMS). Later that night the interim DON called the RP wanting to know who had called her from the facility to let her know Resident #22 was not well. The RP	F 600		

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stated she did not know who the anonymous phone caller was, but she was grateful she was contacted as it may have saved the life of Resident #22. The RP talked to the (former) Administrator about her concerns and the (former) Administrator informed the RP that the facility had learned that a physical therapy staff member had noted a change in the resident earlier that day. The (former) Administrator maintained that they did not have to let the family know if Resident #22 had elevated blood glucose levels, which did not make sense to her. If she had known that Resident #22's blood glucose levels were running high for several days she would have wanted her sent to the hospital to be checked. The RP felt the resident had been neglected and she had talked to the (former) Administrator about all her concerns.

Documentation in the physician orders revealed an order dated 7/11/2024 at 7:00 PM for Resident #22 to be administered ten units of Humalog insulin solution to be injected subcutaneously one time only for a blood glucose exceeding 400 mg/dL and contact the physician in two hours. Humalog insulin is a fast-acting insulin which is absorbed quickly and starts working in about 15 minutes after injection to lower blood glucose levels.

There was no documentation on the July MAR that the order for Humalog insulin was administered to Resident #22 on 7/11/2024 after 7:00 PM.

Documentation on the July MAR revealed Nurse #4 administered Semglee insulin to Resident #4 on 7/11/2024 at 8:58 PM.

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Documentation in the physician orders revealed an order dated 7/11/2024 at 9:00 PM for Resident #22 to be administered ten units of Novolog insulin solution subcutaneously one time for blood glucose exceeding 400 mg/dL and contact the physician in two hours.

There was no documentation on the July MAR that the one-time order for Novolog insulin was ever administered to Resident #22 on 7/11/2024 after 7:00 PM.

There was no other documentation in the electronic medical record of any vital signs taken of Resident #22 on 7/11/2024.

Documentation in the nursing notes for Resident #22 dated 7/12/2024 at 9:48 AM by Nurse #4 revealed, "Physician contacted due to blood glucose exceeding 400 [mg/dL] and order received from physician to administer 10 [units] of Humalog or Novolog and report back after 2 hours. After 2 hours, resident blood [glucose] reading still exceeded 400 [mg/dL] and physician made aware of results. Family arrived and RP requested for resident to be sent to [emergency room] for evaluation. Physician made aware and order received to send resident to [emergency room]. [Director of Nursing] made aware."

An interview was conducted with Nurse #4 on 9/5/2024 at 6:04 PM. Nurse #4 relayed the following information and timeline of events for Resident #22 on the evening of 7/11/2024. Nurse #4 started her 7:00 PM to 7:00 AM shift at 7:00 PM on 7/11/2024. Nurse #4 received the information in a nursing report from Med Aide #4 that the blood glucose level of Resident #22 was above 400 mg/dL on the 4:00 PM medication

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F 600	Continued From page 50 pass. Nurse #4 denied she had any knowledge of the blood glucose level of Resident #22 being at or above 400 mg/dL for several shifts. Nurse #4 stated she assessed Resident #22 and took her vital signs at the start of her shift. Nurse #4 revealed the blood glucose level of Resident #22 was registering as HI or over 400 mg/dL on the glucometer, a device to measure blood glucose levels. Nurse #4 revealed the vital signs of Resident #22 were fine, so she called the on-call physician. Nurse #4 stated she received an order from the physician to administer 10 units of fast acting insulin to Resident #22 and call the physician back in two hours. Nurse #4 stated she went back to check on Resident #22 again at 9:00 PM and all her vital signs were fine. Resident #22 did not have a temperature, elevated blood pressure, or an elevated heart rate. Nurse #4 stated her blood glucose level was still registering as HI or above 400 mg/dL on the glucometer. Nurse #4 was adamant Resident #22 was fine and was responsive. Nurse #4 related that when she pricked the finger of Resident #22 with the lancet, the resident looked at her and rolled her eyes. Nurse #4 stated the family of Resident #22 arrived at the facility stating they received a phone call from an unknown caller telling them something was wrong with Resident #22, and she needed to be sent to the emergency room. The family of Resident #22 looked at Resident #22 and demanded she be sent to the emergency room. Nurse #4 stated she did not know who called the family because the breathing and vital signs for Resident #22 were normal. Nurse #4 reported she was about ready to call the physician because of the elevated blood glucose reading, so she called the physician, and the physician agreed Resident #22 could be sent out per the family wishes. Nurse #4 relayed that she	F 600		

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did all her documentation for the residents at the end of her shift so that all the events of the shift for each resident could be documented, for an explanation for why her nursing note for Resident #22 was dated 7/12/2024, the day after Resident #22 discharged from the facility.

An interview was conducted with the interim DON on 9/5/2024 at 1:58 PM. The interim DON stated she was not made aware of any concerns with the blood glucose levels of Resident #22 until the RP called her on the evening of 7/11/2024 at approximately 8:00 PM or 8:30 PM. The interim DON was told by the RP of a phone call she received from a facility staff member telling her Resident #22 was very ill and needed to be sent to the hospital. The interim DON relayed she called Nurse #4 and was told Resident #22 was still at the facility and was fine. The interim DON further revealed Nurse #4 had explained the following interventions for Resident #22. An assessment had been completed by Nurse #4 revealing an elevated blood glucose level, lethargy, vital signs were fine, the physician was called for orders, and Resident #22 was responsive. The interim DON stated she knew the blood glucose level of Resident #22 was high in the moment on the evening of 7/11/2024 but she was not aware the blood glucose level had been HI over several shifts.

Documentation on an Emergency Medical Services (EMS) report dated 7/11/2024 revealed 911 was called at 9:17 PM and arrived at room of Resident #22 at 9:37 PM. The following information was revealed in the EMS report. Upon arriving at the scene, the facility staff stated Resident #22 had been having an elevated blood glucose level all day and had been alert but not

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F 600	Continued From page 52 acting like herself. The facility staff also told EMS they had been giving Resident #22 insulin as instructed by the resident's physician with no changes in the reading level of HI on the glucose monitor. EMS noted Resident #22 had a glucose reading of HI on their glucose monitor as well. EMS documented Resident #22 as having a heart rate of 140 with respirations in the 40s. Once in the ambulance, Resident #22 remained unresponsive. Documentation on a hospital record dated for a 7/11/2024 admission revealed Resident #22 was diagnosed with sepsis, hyperglycemia, altered mental status, acute renal failure, dehydration, and a urinary tract infection in the emergency room. Resident #22 was discharged from the hospital on 7/24/2024 into the care of the RP with home health services, per the RP's request. An interview was conducted with MD #2, the physician for Resident #22, on 9/9/2024 at 1:12 PM. MD #2 stated he could not recall if he was notified of the elevated blood glucose levels of Resident #22 on 7/9/2024, 7/10/2024, or 7/11/2024. MD #2 explained that if he had been notified of elevated blood glucose levels for Resident #22 during normal business hours, he would have ordered a change in the amount of fast-acting insulin to be administered and requested a call back if there was no change after continuous monitoring of the resident. MD #2 indicated that if those orders did not exist on 7/10/2024 or 7/11/2024 during the day shift then it was likely he was not notified. MD #2 stated he did not recall receiving a phone call on the evening of 7/11/2024 from Nurse #4, but he received phone calls of that type routinely making it difficult to recall a specific phone call of that	F 600		

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type for a resident. MD #2 stated that a blood glucose level of 400 mg/dL was "not good," but having a blood glucose level of 400 mg/dL was an isolated event for this resident making it likely an underlying medical condition was occurring for which he would have had to figure out.

The facility's medical director was interviewed on 9/9/24 at 4:19 PM and details of how the staff had failed to respond to Resident # 22's multiple readings of high blood glucose readings and unresponsiveness prior to EMS transport were discussed with the medical director. The medical director reported facility staff had not shared with him any incidents which would indicate Resident # 22 had been neglected and he was unaware of what had transpired with Resident # 22.

On 9/9/24 at 5:04 PM the facility Administrator and Corporate Nurse Consultant were notified of Immediate Jeopardy based on findings related to Resident # 22.

On 9/10/24 the facility provided the following immediate jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #22 was admitted to the facility on 08/02/2023 and discharged on 07/11/2024. Between the original admission and discharge, she was readmitted on 06/21/2024. The most recent readmission, she was readmitted with diagnoses that included: Type 2 diabetes with diabetic retinopathy without macular edema (a complication of diabetes that can cause vision loss and blindness), schizoaffective disorder,

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F 600	Continued From page 54 dementia, chronic embolism (long-term condition where one or more blood clots block the pulmonary arteries), and thrombosis of distal lower extremity (a blood clot condition that forms within the deep veins, usually of the leg, but can occur in the arms). Review of Resident #22's Medication Administration Records (MAR), indicates; on 7/10/24 at 1:43pm the medication aide (MA #4) notified Unit Manager #2 that Resident #22 had blood glucose levels registering over 400. No evidence that the physician was notified. Resident #22's MAR indicates that Resident #22 received 10 units of Novolog insulin at 1:43pm. Further review of Resident #22's MAR indicates; on 7/11/2024, at 11:47 am, Resident #22's blood glucose was documented to be 400 and 10 units of fast-acting insulin were administered, no evidence that the physician was notified. Review of the Physical Therapy Assistant documentation on 7/11/24 at 3:38 PM indicated the resident was non-responsive, and the Director of Nursing was notified. No documentation of actions taken, no evidence that the physician was notified. The Director of Nursing who was informed is no longer working at the facility. On 7/11/24 at 4:51pm blood glucose documented by MA #4 to be 400. The MAR indicates Resident #22 received 10 units of Novolog insulin. No indication that the physician was notified, or anything else was done. Review of progress notes documented on 7/12/2024 (late entry for 7/11/2024), in Resident #22's medical records indicate (in part); Nurse #4 contacted physician due to Resident #22 blood	F 600		

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glucose exceeding 400. An order was received from the physician to administer ten units of Humalog or Novolog and report back after 2 hours. After two hours, Resident #22's blood glucose reading still exceeded 400 and the physician made aware of results, the note added. Resident #22's family arrived and requested that Resident #22 to be sent to the hospital for evaluation. The physician made aware, and the order received to send resident to hospital, documentation concluded.

A phone interview was conducted on 09/07/2024 by the Assistant Director of Nursing. Nurse #4 indicated; she contacted physician around 7:10pm on 7/11/2024 due to Resident #22's blood glucose exceeding 400. Nurse #4 added she received an order to administer ten units of Humalog or Novolog and report back after 2 hours. Nurse #4 indicated that she recalled Administering 10units of Novolog to Resident #22 per physician order. Nurse #4 further added that, at approximately 9:00pm, she rechecked Resident #22's blood glucose, the reading still exceeded 400. She added the physician was made aware of the results at approximately 9:03pm. Per Nurse #4, Resident #22's family arrived at approximately 9:05pm and requested for Resident #22 be sent to the hospital. The physician was made aware of the request at approximately 9:10pm, and the order was received to send the resident to hospital, Nurse # 4 contacted EMS at 9:17pm, interview concluded.

EMS arrived on scene at 9:32pm. Resident #22 was still non-responsive when EMS arrived. Per EMS report, Resident #22 was found with an elevated heart rate of 140, respirations in the 40s, and with a continued reading of a blood sugar in

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excess of 400 at time of transport. Resident #22 was sent to the hospital for further evaluation and treatment, Resident #22 left the facility at approximately 9:53pm. Resident #22 is no longer in the facility. No other actions taken.

The Governing body led by the Vice President of Operation, the facility Administrator, Regional Director of Clinical Services, and Director of Nursing conducted the root cause analysis on 09/06/2024, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences.

For Resident #22, the Root Cause Analysis (RCA) identified the alleged noncompliance resulted from the failure of the facility employee (Nurse # 4) to follow the professional standard of practice on managing repeated episodes of hyperglycemia for Resident #22 who was non-responsive on 7/11/2024. The RCA further identified that the facility failed to have a system in place medication aides to be informed of the licensed nurse responsible to oversee them while on duty.

The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.

On 7/11/2024, the former Administrator completed an initial report to the State agency and completed the investigation on 7/15/2024 for

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F 600	Continued From page 57 Resident #22. The allegation was unsubstantiated. Per investigation report completed on 7/15/2024, the allegation for Resident #22 was not reported to law enforcement and Adult Protective Services (APS). The former Administrator is no longer employed at the facility. On 09/09/2024 the new Administrator has been educated by the Vice President of Operation on reporting requirements to include reporting to Law enforcement and APS. Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention. The clinical assessment focused on resident's vital signs to include, blood pressure reading, pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated. 100% audit of all current resident's blood glucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a resident with episodes of hypoglycemia and/or	F 600		

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F 600	Continued From page 58	F 600		

hyperglycemia that was not addressed appropriately in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered. If the identified issues indicate neglect, that were not previously reported to the state, law enforcement, and Adult protective services (APS), the facility Administrator will protect all residents by immediately suspending the alleged perpetrator, report the identified issue of neglect to the State agency, law enforcement, and APS within two hours of identification and initiate thorough investigation, immediately. The facility Administrator will report the result of the investigation to the State agency within five working days.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Effective 09/09/2024, facility will ensure all residents remain free from abuse and neglect by following the facility company abuse prohibition policy and providing care in accordance with standard of practice and notifying the physician in a timely manner for any changes in resident's condition.
Effective 09/07/2024, facility employees will ensure residents received necessary care to include assessing, monitoring, addressing a change in condition, identify the seriousness of a

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F 600	Continued From page 59 change in condition, and recognize the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This systemic modification will be accomplished by implementing the following measures: Effective 09/07/2024, licensed nurses will oversee care and services for each resident in the facility. A licensed nurse will be informed at the beginning of the shift, through the daily schedule, of his/her responsibility to oversee certified medication aide(s) if any. Effective 09/07/24, Director of Nursing, Assistant Director of Nursing, Unit Coordinator (#1 or #2), Weekend Supervisor, and/or Scheduling Coordinator will be responsible to update daily schedule for nursing staff (licensed nurses, medication aides, and certified nursing aides). The daily schedule will inform each nursing staff of their assignment and responsibilities to include responsibility for licensed nurses to oversee medication aides (if any). The Facility Administrator will educate Director of Nursing, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator. The education focused on the importance of ensuring a daily nursing schedule is completed and indicate the responsibility of each nursing staff to include the responsibilities of the licensed nurse to oversee the medication aides. This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24	F 600		

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F 600	Continued From page 60 will not be allowed to work until educated. The Director of Nursing will complete this education for any newly hired, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator during the orientation process effective 9/8/2024. Effective 09/07/2024 the assigned licensed nurse will be responsible to provide necessary care to include assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for their assigned residents, and/or those assigned to the medication aide under the nurse's supervision. Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident's medical records, and inform a Nurse on duty immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services, and notifying the attending physician in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 600		

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Effective 09/07/2024, facility licensed nurses on duty will administer medication related to hypoglycemia and/or hyperglycemia, including glucagon for low blood sugar, and/or insulin for high blood glucose, based on physician orders and document the administration of such medication in each resident's clinical record.

Effective 09/07/2024, residents with blood glucose over 400 will receive 10 units of fast acting insulin, (Humalog or Novolog), blood glucose will be rechecked within 30 minutes, or per physician order, after the administration of insulin, if blood glucose remains over 400, resident's physician will be notified for further evaluation and/or treatment. This protocol is implemented effective 09/07/2024.

100% education of all current staff to include full-time, part-time, and as needed employees will be completed by the Administrator, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator. The emphasis of this education includes but is not limited to, the importance of providing care to all residents in the facility. The education also focused on facility abuse prohibition policy and procedures to include prevention of resident neglect by following physician orders related to administration of insulin for residents with high blood glucose and notifying physician in accordance with physician orders and when there is an instance of sustained elevated blood glucose levels over a period of time. This education also emphasized the definition of neglect as the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 600	Continued From page 62	F 600		

This education will be completed by 09/08/2024. Any staff members not educated by 09/09/2024 will not be allowed to work until educated. The Administrator, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will monitor and track the completion of this education and provide it for any newly hired employee during the new hire orientation, and annually.

100% education of all licensed nurses and Medication aides, to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to:
1. The importance of administering medication to include insulin, glucagon, and other medications per physician order.
2. The importance of ensuring each resident is assigned to a licensed nurse to oversee his/her care including provision for assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
3. The importance for each medication aide to be aware of their assigned licensed nurse at the beginning of their shift (through the daily schedule that will indicate the nurse who is responsible to oversee them)
4. The implementation of hyperglycemia protocol includes administration of fast acting

F 600 Continued From page 63 F 600

insulin and rechecking blood sugar within 30 minutes and notifying physician for any other orders.
5. The importance of calling 911 for medical emergencies that require medical attention at the acute care center. (The education emphasized that any staff member can call 911 when indicated.)
6. The importance of documenting blood glucose findings in resident's medical records.
7. For medication aides, the education also covered the importance to report to the charge nurse immediately any blood glucose level less than 60, greater than 200 or based on the physician order.

This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation.

Alleged immediate jeopardy removal date: 09/09/2024.

On 9/12/24 the following was done to validate the facility's immediate jeopardy removal plan:

Review of records revealed documentation confirming the completion of audits and in-service training per the facility's removal plan.

A review of staffing schedules revealed that there was a designation on the schedule noting which

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F 600	Continued From page 64 licensed nurse was assigned to cover for any Medication Aide. Beginning at 9:45 AM on 9/12/24 multiple staff members were interviewed regarding in-service training the facility had provided. Staff were able to report details of their training and validate they attended. Staff were also interviewed regarding whether they had witnessed any resident go without medical care or be neglected during the past week for failure of assessment and notification of the physician of changes. There were no reports of a lack of medical care or neglect reported for any residents. The Medication Aide, who was working on 9/12/24, was aware of which nurse was to help her. The assigned nurse was observed checking on the Medication Aide to ensure the Medication Aide was not in need of any assistance on 9/12/24. A random interview was conducted on 9/12/24 at 1:35 PM with an alert and oriented diabetic resident regarding her medical care. The resident reported no problems with her diabetic care and reported the staff were "very careful" to keep a check on her blood sugar. She had no care concerns. The facility's immediate jeopardy removal date of 9/9/24 was validated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		10/14/24

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F 609	Continued From page 65 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to report an allegation of neglect of services to law enforcement and adult protective services for one (Resident #22) of three residents reviewed for abuse. Findings included: Documentation in the facility abuse/neglect/misappropriation/crime policies and procedures dated as effective 2/5/2023 revealed under procedure, there was the requirement of reporting to the state agency, adult protective services, and local law enforcement authorities for alleged violations of neglect.	F 609	F609 Corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #22 no longer in the facility, no other actions taken for resident #22 On 09/09/2024 the new Administrator has been educated by the Vice President of Operation on reporting requirements to include reporting to Law enforcement and Adult Protective Services (APS). How will you identify other residents having the potential to be affected by the same deficient practice?	

F 609

Continued From page 66

Documentation on an initial allegation report faxed to the state on 7/16/2024 at 12:14 AM revealed the facility was made aware of an allegation of neglect on 7/15/2024 at 9:05 PM for an incident that occurred on 7/11/2024. The documentation revealed a family member of Resident #22 alleged "resident's catheter wasn't reinserted, blood sugar was high, and resident [did] not receive Eliquis. Eliquis was [discontinued on] 6/1/24. It was alleged the [Certified Nursing Assistant] improperly placed briefs on the resident. Resident was sent to [Emergency Room]." The initial allegation report was blank under notification of law enforcement and notification of county Department of Social Services adult protective services.

Documentation on an investigation submitted to the state on 7/19/2024, as the 5-day report revealed the facility had unsubstantiated the allegation of neglect. The investigation stated in part, "The resident's family arrived at the facility and demanded that she (Resident #22) be sent out to the hospital. Neglect is unsubstantiated due to the nurse following MD (medical doctor) orders." The 5-day report was blank under notification of law enforcement and notification of county Department of Social Services adult protective services.

Documentation in a removal plan for F600 Neglect of Care and Services for Resident #22 cited at an immediate jeopardy level of scope and severity the facility acknowledged "Per investigation report completed on 7/15/2024, the allegation for Resident #22 was not reported to law enforcement and Adult Protective Services (APS). The former Administrator is no longer

F 609

100% audit was done on 10/01/2024, by the facility Administrator on all Facility Reported Incidents (FRI) that were completed and sent to the State agency in the last 30 days to ensure that they were reported to the administrator, Law enforcement, and Adult protective services. No other resident identified to have not been reported to the administrator, law enforcement, and Adult protective services. Findings of this audit are documented on a FRI review tool located in the facility compliance binder.
Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:
Effective 09/09/2024, facility Administrator will ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services).
100% education of all key personnel in the facility to include an Administrator, Director of Nursing, Social workers, and Rehab Director will be completed by the Regional Director of Clinical Services. The emphasis of this education includes but not limited the importance of reporting any

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F 609	Continued From page 67 employed at the facility. On 09/09/2024 the new Administrator has been educated by the Vice President of Operation on reporting requirements to include reporting to Law enforcement and APS." The former Administrator was not available for interview.	F 609	alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property to the Administrator immediately who will in turn report to the State survey agency, law enforcements and Adult protective services immediately, but not later than 2 hours after the allegation is made. This education will be completed by 10/14/2024. Any key personnel not educated by 10/14/2024 will not be allowed to work until educated. The Administrator, and/or Director of Nursing will complete this education for any newly hired key personnel during the new hire orientation, and annually. The Regional Director of Clinical services will complete this education for any new Administrator effective 10/14/2024. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Effective 10/07/2024, Regional Director of Clinical Services (RDCS), and/or Vice President of Operation will monitor compliance with notification of FRI□s to ensure state survey agency, APS, and law enforcement is informed. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 10/07/2024, the Facility	

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F 609	Continued From page 68	F 609	Administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with family, staff, and physicians the facility failed to ensure a thorough investgation was conducted when they received an allegation of neglect for	F 610	F610 Corrective actions will be accomplished for those residents found to be affected by the deficient practice?	10/14/24

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F 610	Continued From page 69 one (Resident # 22) of one sampled resident whose family lodged a complaint of neglect. Resident # 22's family member filed an allegation of neglect after receiving an anonymous phone call that Resident # 22 needed to be sent to the hospital. Interviews revealed the anonymous phone call was made by a medication aide when she feared the resident was about to die and was not receiving medical care while under the care of Nurse # 4. Interview with the medication aide revealed she had previously reported concerns regarding Nurse # 4 not responding to an emergeny situation and former administration did not investigate. The findings included: Review of the facility's policy entitled "Abuse/Neglect, Missappropriation/ Crime Reporting Requirements/ Investigations" revealed nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alledged victims and witness, and involving other appropriate individuals, agents, or authorities. Documentation on an Emergency Medical Services (EMS) report dated 7/11/2024 revealed 911 was called at 9:17 PM for Resident # 22 while she resided at the facility. EMS arrived at the room of Resident #22 at 9:37 PM. The following information was revealed in the EMS report. Upon arriving at the scene, the facility staff stated Resident #22 had been having an elevated blood glucose level all day and had been alert but not acting like herself. The facility staff also told EMS they had been giving Resident #22 insulin as instructed by the resident's physician with no changes in the reading level of High on the	F 610	Resident #22 no longer in the facility, no other actions taken for resident #22 On 10/07/2024 the new Administrator has been educated by the Vice President of Operation on the company abuse investigation policy to include the importance initiating a thorough internal investigation of the alleged/suspected occurrence, the education emphasized on the investigation protocol to include, but not be limited to, collecting evidence, interviewing alleged victims and witness, and involving other appropriate individuals, agents, or authorities. How will you identify other residents having the potential to be affected by the same deficient practice? 100% audit was done on 10/01/2024, by facility Administrator on all Facility Reported Incidents (FRI) that were completed and sent to the State agency in the last 30 days to ensure that they were thoroughly investigated to include, but not limited to statement(s) from the alleged perpetrator and/or victims. Findings of this audit are documented on a FRI investigation review tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 09/09/2024, facility Administrator will ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are thoroughly investigated, to include statement from the alleged perpetrator, and/or witnesses	

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glucose monitor. EMS noted Resident #22 had a glucose reading of High on their glucose monitor as well. EMS documented Resident #22 as having a heart rate of 140 with respirations in the 40s. Once in the ambulance, Resident #22 remained unresponsive.

Documentation on a hospital record dated for a 7/11/2024 admission revealed Resident #22 was diagnosed with sepsis, hyperglycemia, altered mental status, acute renal failure, dehydration, and a urinary tract infection in the emergency room.

An interview was conducted with the responsible party (RP) for Resident #22 on 9/3/2024 at 3:42 PM and the following information was provided. On 7/8/2024 the RP checked on Resident #22 before going out of town and she was okay. The RP heard nothing all week from the facility. On 7/11/24 around 7:30 PM to 8:00 PM she saw she had several missed calls on her phone. She then picked up on the next one. It was from a private number. The person on the phone did not identify themselves but told the RP, " You need to come now and check on your mother. It is an emergency. She needs to be sent out." The RP did not know what was going on because the facility did not notify her that Resident #22 was sick. The RP called another family member who was local to the facility and asked him to go to the facility to see Resident #22. The family member arrived at the facility around 8:30 to 8:45 PM to find Resident #22 was not responding. Nurse #4 walked in with a blood glucose monitor and said the doctor ordered to watch her blood glucose and they were to call the doctor back in two hours. Nurse #4 seemed angry because the family wanted Resident #22 sent to the

F 610

if any.
Effective 09/09/2024, the facility Administrator will report the results of all investigations to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken by the administrator based on facility policies and procedures.
100% education of all key personnel in the facility to include an Administrator, Director of Nursing, Social workers, and Rehab Director will be completed by the Regional Director of Clinical Services. The emphasis of this education includes but not limited the importance of completing a thorough investigation for any alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. The education emphasized that the investigation will be led by the Administrator who will in turn report to the result of the investigation to the State survey agency within 5 working days.
This education will be completed by 10/14/2024. Any key personnel not educated by 10/14/2024 will not be allowed to work until educated. The Administrator, and/or Director of Nursing will complete this education for any newly hired key personnel during the new hire orientation, and annually. The Vice president of Operation will complete this education for any new Administrator effective 10/14/2024.

How will the facility monitor its corrective

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW** **RALEIGH, NC 27616**

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F 610	Continued From page 71 emergency room. Since Resident #22 was not responding the family member insisted that Resident #22 be sent to the emergency room and finally Nurse #4 called emergency medical services (EMS). Later that night the interim DON called the RP wanting to know who had called her from the facility to let her know Resident #22 was not well. The RP stated she did not know who the anonymous phone caller was, but she was grateful she was contacted as it may have saved the life of Resident #22. The RP talked to the former Administrator about her concerns and the former Administrator informed the RP that the facility had learned that a physical therapy staff member had noted a change in the resident earlier that day. The former Administrator maintained that they did not have to let the family know if Resident #22 had elevated blood glucose levels, which did not make sense to her. If she had known that Resident #22's blood glucose levels were running high for several days she would have wanted her sent to the hospital to be checked. She felt the resident had been neglected and she had talked to the former Administrator about all of her concerns. Review of Resident # 22's record revealed documentation Resident # 22 was incoherent with extreme lethargy hours prior to EMS being called and that her pupils would not react to light. The documentation written by the Physical therapy Assistant (PTA) #1 at 3:58 PM on 7/11/24 at 3:58 PM revealed, "PTA facilitated that [Resident #22] get [out of bed] for the purpose of attempting goals. [Resident #22] responded [by demonstrating] extreme lethargy, incoherent mumbling, [nonresponsive] pupils/eye movement to bright light. PTA attempted to have [Resident #22] sit [on edge of bed] with [Resident #22	F 610	actions to ensure that the deficient practice is being corrected and will not recur? Effective 10/07/2024, Regional Director of Clinical Services (RDCS), and/or Vice President of Operation will monitor compliance with investigation of all FRI�s to ensure the investigation is thorough, and appropriate measures are taken to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 10/07/2024, the Facility Administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	

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F 610	Continued From page 72	F 610		

[demonstrating] inability to arise from sleep/difficulty to hold head. Nursing [Med Aide #4], [Director of Nursing], [Physical Therapist/Occupational Therapist] notified regarding [Resident #22's] decrease in status. Continue [with plan of care.]" The PTA #1 documentation, according to the RP, had been referenced by the Administrator as having knowledge that the resident was not well prior to EMS being called at 9:17 PM without any interventions being taken.

An interview was conducted with PTA #1 on 9/6/2024 at 4:45 PM. PTA #1 revealed the following information. PTA #1 stated she did not recall the exact time she went to see Resident #22 on 7/11/2024. PTA #1 confirmed she found Resident #22 in a nonresponsive condition on that day, so she went to the Med Aide on the hall, the interim Director of Nursing, the Physical Therapist, and Occupational therapist to let them know of her concern for Resident #22.

Further review of Resident # 22's July 2024 medication administration record (MAR), orders, and progress notes revealed elevated blood sugar readings for consecutive days prior to the resident being transferred by EMS on 7/11/24 in a nonresponsive state with multiple blanks on the MAR when insulin should have been administered per orders.

An interview was conducted with MD #2, the physician for Resident #22, on 9/9/2024 at 1:12 PM. MD #2 stated he could not recall if he was notified of the elevated blood glucose levels of Resident #22 on 7/9/2024, 7/10/2024, or 7/11/2024.

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F 610	Continued From page 73 MA (Medication Aide) # 3 was interviewed on 9/3/24 at 10:55 AM and again on 9/9/24 at 10:14 AM and reported the following. She had been the person who had anonymously called Resident # 22's RP. She had been working that night and heard staff talking about the resident was "about to go to glory." She was not assigned to Resident # 22, but she was concerned and did not want her to pass away. She did not think the family knew the resident was sick. She asked Nurse # 4 to do something, and Nurse # 4 told her to "quit playing Gray's Anatomy (a television show) and mind her own business. She had reported to administrative staff in previous times that Nurse # 4 had not responded in an emergency situation and nothing was done. Therefore, she called Resident # 22's RP to let the RP know she needed to come right away to the facility because Resident # 22 needed to go to the hospital. The following morning, she was asked about whether she had called the family by the former Administrator and she had told the former Administrator, "No," because they had not done anything before. She did not want to get in trouble for going outside her scope of practice. MA # 3 reported that she had reported to the former Administrator, Unit Manager # 2, and the ADON when Resident # 21 (another resident) was not responding and had a blood sugar in the 30s. That had been a few weeks earlier than when Nurse # 4 did not respond to Resident # 22. The date Nurse # 4 had not responded to Resident # 21 was on 6/28/24. On that date she (MA # 3) had gone to Nurse # 4 and Nurse # 4 did not come right away during the incident with Resident # 21. According to MA # 3 she had never been asked to provide written statements regarding anything she had reported about either resident.	F 610		

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F 610	Continued From page 74 Record review revealed on 7/19/24 the former Administrator had submitted to the state agency a five- day report regarding alleged neglect related to Nurse # 4 and Resident # 22. The neglect allegation had been initiated by the RP. No where in the report findings, which was submitted to the state agency, did it make note that the resident had been observed by therapy staff to not be responding hours before EMS was finally called while the resident had been under the care of Nurse # 4. The Administrator had concluded there had been no neglect substantiated for the resident. The facility Nurse Consultant was interviewed on 9/11/24 at 11:52 AM and reported the following information. The Administrator, who had been responsible for the investigation into alleged neglect by Nurse # 4, was no longer at the facility. He had looked and found no statements from staff regarding alleged neglect regarding how Nurse # 4 had cared for Resident # 21 and Resident # 22. The Nurse Consultant was interviewed regarding 1)the RP's statement that the Administrator had been aware the PTA knew Resident # 22 was not well on 7/11/24 2) that the PTA documentation was clearly in the record that the resident was not responding hours earlier before transport and 3) how the former Administrator could have come to the decision she did if a thorough investigation had been done when the former Administrator was aware of the documentation that the resident was not responding hours earlier before transport. The facility Nurse Consultant responded he could not say how the previous Administrator came to her conclusion, and she was no longer in charge of the facility.	F 610		

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F 624	Continued From page 75	F 624		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and family interviews the facility failed to refer a resident for home health services and order necessary equipment for 1 of 1 resident reviewed for discharge (Resident #6). The findings included: Resident #6 was admitted to the facility on 7/25/24 with diagnoses including cerebrovascular disease. Resident #6's admission Minimum Data Set (MDS) assessment dated 7/31/24 revealed she was cognitively intact. She had no mood symptoms or behaviors. She was coded as planning to discharge to the community. Review of the discharge summary dated 8/26/24 indicated that Resident #133 was discharged from the facility on 8/26/24. The discharge summary was signed by Social Worker #2. The discharge summary indicated a rollator walker had been recommended. Home Health assistance with activities of daily living and home health physical therapy had been recommended	F 624	F624 What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #6 is no longer in the facility. How will you identify other residents having the potential to be affected by the same deficient practice? 100% of all planned discharges to the community for the last 30 days were audited on 10/07/2024 by the Assistant Administrator to identify any other residents who were sent home without preparation for a safe/orderly transfer/discharge. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Effective 10/07/204, the facilities administration team including social services, and assistant administrator, resumed the process of reviewing discharges for the last 24 hours and/or from the last clinical meeting to insure a safe and orderly discharge has been set	10/14/24

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F 624	Continued From page 76 by the physical therapist. An interview was conducted with Resident #6's family member on 8/28/24 at 2:47 PM who stated Resident #6 discharged home on 8/26/24 but there was no plan for equipment the resident might need when she got home. The resident had still been weak, and the family had asked about getting a transport chair and some sort of lift. The facility had not arranged for any homecare or new medical equipment. Once home, the family member communicated with Social Worker #1, and he tried to assist with getting services and equipment arranged. She stated the family had managed to care for the resident without the ordered home health nurse aide and ordered equipment. She further stated the home health physical therapist had come and seen the resident on 8/27/24. Record review revealed no lift had been recommended by the facility physical therapist. A physician's order for Resident #6 dated 8/29/24 was reviewed and indicated an order for a referral for home healthcare, occupational and physical therapy. Social Worker #2 was unavailable for interview. An interview was conducted with Social Worker #1 on 8/29/24 at 3:35 PM. He stated he was not responsible for discharge planning for Resident #6 but had been trying to assist the family with needs since the resident had been discharged. Social Worker #1 stated he was not sure what Social Worker #2 did to plan for Resident #6's discharge. He stated he had spoken with Resident #6's family member to help facilitate	F 624	up for residents who are discharged to the community. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Assistant Administrator will re-educate social worker on the importance of completing discharge planning psychosocial assessment and implement the discharge planning/preparation process that focuses on the resident□s discharge goals, with the resident as the active partners for effectively transition to the discharge location. The education also emphasized that; discharge care plan must be developed on admission based on resident□s desires. This education is completed on 10/14/2024 and will be added on the new hire orientation for all new social worker. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Effective 10/07/2024, Assistant Administrator and Social Worker will monitor compliance with preparing a safe and orderly discharge. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 10/14/2024, Assistant Administrator will report findings of this	

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F 624	Continued From page 77 home health services on 8/28/24. An interview was conducted with the Corporate Nurse Consultant on 8/31/24 at 11:30 AM and he stated he was not aware of the issues with discharge planning. He stated Social Worker #1 was new to the facility and was putting systems in place to ensure discharge planning occurred as needed. The Corporate Nurse Consultant when Social Worker #2 returns to the facility those discharge planning systems will be utilized in the future.	F 624	monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.	
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on family interview, record review, staff interviews, and emergency medical services (EMS) report the facility failed to obtain physician orders for one (Resident #4) of five residents reviewed for admission procedures. Findings included: There was no documentation in the electronic medical record of Resident #4 other than the hospital discharge summary dated as uploaded by the facility on 7/10/2024. The hospital discharge summary, for the 7/3/2024 to 7/10/2024 hospital stay, revealed Resident #4 had the discharge diagnoses of generalized muscle weakness, chronic lymphocytic leukemia, age related physical debility, primary hypertension, Stage 3 chronic kidney disease,	F 635	F635 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #4 no longer in the facility, no other actions taken for resident #4 Identification of other residents having the potential to be affected by the same deficient practice: 100% of all new admission to the facility for the last 30 days were audited on 10/07/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with no admission orders. No other resident identified. Findings of this audit are documented on the new	10/14/24

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F 635	Continued From page 78 Type 2 diabetes mellitus, and a history of transient ischemic attack (stroke). The hospital discharge summary listed an expected medication list at discharge but did not include any orders for oxygen. There was no documentation of any orders or any admission documentation in the electronic medical record to indicate initial orders were obtained for Resident #4 from a facility physician. An interview was conducted with the family member of Resident #4 on 8/28/2024 at 12:53 PM. The family member provided the following information about the stay of Resident #4 in the facility. Resident #4 arrived from the hospital at the facility on 7/10/2024 at 5:30 PM. Resident #4 was paralyzed and was unable to move on his own. Resident #4 was receiving oxygen at the facility from an oxygen concentrator that sounded like a jet engine and was very loud. The nurse aide told the family they would let the nurse for the hall know of the concern for the oxygen concentrator. The nurse for the hall never came down to the room so the family member went to the desk to seek her assistance. The nurse at the desk told the family member of Resident #4, she would be down to the room to help them in a minute and that she was very busy at that moment. The family stated at that point Resident #4 had been in the facility for several hours and nobody had come to assess him or make sure he was receiving adequate oxygen. The family of Resident #4 called for EMS to take Resident #4 back to the hospital at approximately 7:00 PM. As Resident #4 was being wheeled out of the facility on a stretcher the nurse at the desk told the family she was sorry they did not feel welcome in the facility.	F 635	admission order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 10/07/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe all orders to resident□s medical records to include medication orders and other orders that are necessary for immediate care in the facility. Any identified need for immediate care that is not included in the discharge summary will be communicated to the facility attending physician immediately for clarification. Effective 10/07/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, modified the review process for new admission/readmission to ensure that the review include all residents who arrive in the facility and leave before the next clinical meeting and validate those resident had an admission orders for immediate care. Additionally, if there are any immediate care needs not included on the discharge summary, the clinical team will validate the clarification was obtained from the discharging facility and/or resident□s attending physician. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.	

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An interview was conducted on 8/30/2024 at 9:31 AM with Nurse #2, who was assigned to care for Resident #4 on 7/10/2024 upon admission. Nurse #2 stated she remembered on 7/10/2024 the facility was receiving a lot of new admissions. Nurse #2 revealed she was not able do any of the admission paperwork on 7/10/2024 because she was a licensed practical nurse (LPN) and not a registered nurse (RN). Nurse #2 explained that she did not do any assessments or any of the initial documentation for Resident #4, and that a registered nurse came over to the hallway to assist her with admissions. Nurse #2 stated she did not go down to the room to see Resident #4, but did speak to the family as EMS left with the resident to return to the hospital.

Nurse Aide (NA) #5 was interviewed on 8/29/2024 at 4:14 PM. NA #5 revealed she was an agency nurse aide who was assigned to care for Resident #4. NA #5 stated Resident #4 was already in bed when she arrived for work, so she did not know when the resident arrived at the facility. NA #5 stated the oxygen concentrator in the room for Resident #4 was making a loud rumbling noise and was aggravating the resident. NA #5 stated she was trying to be helpful, so she went looking for another oxygen concentrator and located one in another resident's room. NA #5 stated she did not know anything about oxygen concentrators, so she went to ask the nurse at the desk (Nurse #2) for assistance. Nurse #2 said she was too busy to come to the room, so NA #5 revealed she asked a Medication Aide on another hall for assistance.

An interview was conducted with Medication Aide (Med Aide) #3 on 9/3/2024 at 12:13 PM. Med

F 635

DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring each resident has admission order for immediate care. The education also emphasized that these orders should, at a minimum, include dietary, medications (if necessary) and routine care to maintain or improve the resident�s functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/14/2024, DON and/or ADON will monitor compliance with admission order transcription for immediate care by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team validated each resident had the admission orders in resident�s electronic medical records. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly

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F 635	Continued From page 80 Aide #3 revealed the following information. Med Aide #3 was a medication aide on an adjoining hall to the hall for which Resident #4 resided. Med Aide #3 went to the room of Resident #4 because NA #5 requested assistance with an oxygen concentrator because the oxygen concentrator was too loud. Med Aide #3 stated the orders from the hospital were laying in a folder in the room of Resident #4 she assumed those were the orders called into the facility from the hospital. Med Aide #3 stated she thought the physician orders for the oxygen concentrator were in that folder. Med Aide #3 stated she tried to hook up the humidifier bottle on another oxygen concentrator, but Resident #4 was struggling a little to breathe. The family opted to call EMS before she could get an alternate oxygen concentrator to work. An interview was conducted with Unit Manager #2 on 8/30/2024 at 3:20 PM. Unit Manager #2 revealed it was very difficult admitting residents on 7/10/2024 because the facility was trying to transition from one medical record database to another. Unit Manager #2 stated she was only informed of Resident #2 and an issue with an oxygen concentrator as the family was ready to leave with the resident. Unit Manager #2 indicated the oxygen concentrator for Resident #2 was working but it was louder than normal. Unit Manager #2 stated Resident #4 was not in distress when he left the building and was calm as EMS took him away. Unit Manager #2 stated it was the responsibility of Nurse #2 to obtain physician approval of the orders for the care of Resident #4. An interview was conducted with the facility nurse consultant on 8/31/2024 at 7:58 AM. The facility nurse consultant acknowledged the facility had	F 635	for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Admission orders review monitoring tool located in the facility compliance binder. Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.	

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F 635	Continued From page 81 problems with the admission process in the beginning of July 2024 and he confirmed he was unable to locate any additional documentation or information regarding the admission of Resident #4.	F 635		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		10/14/24

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F 655	Continued From page 82 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to create a person-centered baseline care plan and provide a summary to the residents and/or responsible party within 48 hours of admission for 3 (Resident #6, Resident #7, Resident #10) of 5 residents reviewed for new admission procedures. Findings included: 1. Resident #7 was admitted to the facility on 8/19/2024 with multiple diagnoses some of which included Type 2 Diabetes, protein calorie malnutrition, gastrostomy status, and chronic kidney disease stage 3. Documentation in the care plan written by the Minimum Data Set (MDS) /Care plan coordinator initiated on 8/20/2024 for Resident #7 did not address discharge planning. Documentation on an Admission Minimum Data Set (MDS) assessment dated 8/25/2024 revealed Resident #7 was cognitively intact. Resident #7 was coded as previously, prior to current illness, as being independent with self-care, mobility,	F 655	F655 What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #6 is no longer in the facility. Resident #7 is no longer in the facility. Resident #10 is no longer in the facility. How will you identify other residents having the potential to be affected by the same deficient practice? 100% audit was done on all residents in the facility by the Minimum data set (MDS) nurse on 10/01/2024 to ensure that they have a baseline care plan in place or comprehensive care plan completed in the facility electronic health records. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Effective 10/07/2024, an admitting licensed nurse on duty will complete an admission/readmission data collection tool in electronic health records, that will automatically develop a baseline care	

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stairs, and functional cognition. Resident #7 was coded as requiring substantial or maximal assistance for all activities of daily living upon admission to the facility, except for eating, for which he required partial or moderate assistance.

An interview was conducted with Resident #7 on an initial tour on 8/28/2024 at 10:24 AM and again on 8/29/2024 at 11:08 AM for follow-up questions. Resident #7 provided the following information. Resident #7 stated his greatest desire was to go home. Resident #7 acknowledged that when he first arrived at the facility, he required a lot of help and therapy services. Resident #7 stated that he was currently able to walk around, catheterize himself as needed, eat, and drink on his own, and meet his own activity of daily living needs. Resident #7 stated he found the food at the facility to be unbearable, but he ate it because he had to. Resident #7 expressed he wanted to return home and no longer sit in the facility watching television. Resident #7 revealed he told a social worker a couple of days ago he wanted to go home but heard nothing back. Resident #7 stated nobody had discussed his care plan with him and nobody listened when he told them he wanted to go home now.

Documentation in an occupational therapist note dated 8/27/2024, written by the Rehabilitation Services Manager, revealed, "[Resident #7] in bed upon this writer's arrival in room. [Resident #7 informed his writer that [Medical Director] told him yesterday that nursing to remove catheter. [Resident #7] educated on plan of [treatment] and [Interdisciplinary team] made aware of [Resident #7] requesting a [discharge] care plan."

An interview was conducted with the

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plan care plan for each resident that will includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards..
Effective 10/07/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, modified the review process for new admission/readmission to ensure that the review include validation that admission/readmission data collection tool is completed, and hence baseline care plan is developed for all residents who was admitted to the facility in the last 24 hours or from the last clinical meeting. This process will be incorporated into the daily clinical meeting. Any negative findings will be addressed promptly and documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.
DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring admission/readmission data collection tool is completed and hence a baseline care plan is developed. The education also emphasized that; baseline care plan should include the minimum healthcare information necessary to properly care for a resident including, but not limited to; Initial goals based on admission orders, physician orders, dietary orders, therapy services, social

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F 655	Continued From page 84 Rehabilitation Services Manager on 8/29/2024 at 11:15 AM. The Rehabilitation Services Manager explained on 8/28/2024 she discussed the request of Resident #7 to go home with the interdisciplinary team during the morning meeting. The Rehabilitation Services Manager explained that home health services and therapy services would have to be set up for Resident #7 to go home, and the facility Social Worker was not in the morning meeting on 8/28/2024 for her to let him know of the request to go home of Resident #7. The Rehabilitation Services Manager stated Resident #7 was supposed to have a "jump start" meeting or an initial care plan meeting within 48 hours of his admission to the facility. The Rehabilitation Services Manager stated she did not receive any notice of a jump start meeting for Resident #7 and she did not attend. The Rehabilitation Services Manager stated she would immediately let the Social Worker know to begin discharge planning for Resident #7 now that it had been brought to her attention by the surveyor how urgently he wanted to go home. An interview was conducted with the facility Social Worker on 8/29/2024 at 2:51 PM. The Social Worker revealed it was his second week in employment at the facility. The Social Worker stated a jump start meeting was held within 42 hours of admission during which a nurse would explain goals and discharge would be discussed with the resident or their family. The Social Worker stated he was unsure who was setting up care plan conferences or jump start care plan conferences prior to his employment at the facility. The Social Worker did not know if a jump start meeting was held for Resident #7. The Social Worker stated he immediately started	F 655	services, and Preadmission Screening and Resident Review (PASARR) recommendation, if applicable. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/07/2024, the Administrator, Assistant Administrator, DON and/or ADON will monitor compliance with baseline care plan completion by validating its completion in electronic health records and validate that the clinical team had verified each new admitted resident had a completed admission/readmission data collection tool that triggers baseline care plan in resident�s electronic medical records. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Baseline review monitoring tool located in the facility compliance binder. Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 655	Continued From page 85 discharge preparations for Resident #7 that day (8/29/2024) since it was brought to his attention by the Rehabilitation Services Manager. The Social Worker stated he was working to set up home health services and durable medical equipment delivery for Resident #7. The Social Worker stated the facility was not holding Resident #7 hostage and revealed Resident #7 cried and hugged him when he found out he was able to go home. An interview was conducted with the facility Dietary Manager on 8/30/2024 at 8:23 AM. The Dietary Manager stated he did not attend the jump start meeting for Resident #7 and he did not recall if he met with Resident #7 to obtain his initial food preferences. The Dietary Manager stated he thought he had a family emergency arise on the day of the jump start meeting for Resident #7. An interview was conducted with the MDS/Care Plan coordinator on 8/30/2024 at 9:53 AM. The MDS/Care Plan coordinator stated baseline care plans were generated by the unit managers during the admission assessments. The MDS/Care Plan coordinator stated the Social Worker was notifying residents and family of care plan meetings and setting up discharge planning. The MDS/Care Plan coordinator did not recall creating the initial care plan for Resident #7 nor did he attend the jump start meeting for Resident #7. 2. Resident #6 was admitted to the facility on 7/25/24 with diagnoses including cerebrovascular disease. She discharged to the community on 8/26/24.	F 655	Compliance date 10/14/2024.	

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Resident #6's admission Minimum Data Set (MDS) assessment dated 7/31/24 revealed she was cognitively intact.

Resident #6 was discharged home on 8/26/24 and a review of the medical record revealed the facility failed to have documented evidence of a baseline care plan.

An interview was conducted with the MDS/Care Plan Coordinator on 8/30/2024 at 9:53 AM. The MDS/Care Plan Coordinator stated baseline care plans were generated by the unit managers during the admission assessments. The MDS/Care Plan Coordinator was unable to recall if he created the baseline care plan for Resident #6.

An interview was conducted with the facility Nurse Consultant on 8/31/2024 at 8:40 AM. The facility nurse consultant acknowledged the facility had problems with the admission process in July 2024. He stated processes were being developed to ensure baseline care plans were completed.

3. Resident # 10 was admitted to the facility on 7/22/24 with diagnoses that included osteoarthritis and anxiety disorder. Resident was admitted to the hospital on 8/17/24 and readmitted to the facility on 8/27/24.

Resident #10's admission MDS assessment dated 7/24/24 revealed he was cognitively intact.

Record review revealed the facility failed to have documented evidence of a baseline care plan.

An interview was conducted with the MDS/Care

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F 655	Continued From page 87 Plan Coordinator on 8/30/2024 at 9:53 AM. The MDS/Care Plan Coordinator stated baseline care plans were generated by the unit managers during the admission assessments. The MDS/Care Plan Coordinator was unable to recall if he created the baseline care plan for Resident #10. An interview was conducted with the facility Nurse Consultant on 8/31/2024 at 8:40 AM. The facility nurse consultant acknowledged the facility had problems with the admission process in July 2024. He stated processes were being developed to ensure baseline care plans were completed.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		10/14/24

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F 656	Continued From page 88 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, staff, family interview the facility failed to develop and implement a comprehensive care plan to address individual needs related to a resident refusing care secondary to mental illness (Resident # 1), a resident's need for specialized skin care secondary to a genetic disorder (Resident # 2), care for an indwelling catheter (Resident # 16), and discharge planning (Residents # 6). This was for four (Residents # 1, #2, #6, #16) residents of eleven residents whose care plans were reviewed to determine if they addressed individual needs. The findings	F 656	F656 What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #1 has had her care plan updated to include the issues related to skin and refusal of care by MDS nurse on 10/08/2024. Resident #2 has had his care plan updated to include the issues related to	

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included:

1. Resident # 1 was admitted to the facility on 3/1/17 and had diagnoses in part which included a degenerative neuromuscular disease and bipolar disorder with psychotic features.

Resident # 1's quarterly Minimum Data Set assessment, dated 6/19/24, coded Resident # 1 as cognitively intact and as being totally dependent on staff for bathing, dressing, hygiene, and bed mobility. The resident was not coded as refusing care during the time period of the assessment.

Resident # 1's comprehensive care plan was not currently part of the facility's new medical record system which had gone into effect in July 2024. The facility staff provided a copy of the resident's comprehensive care plan from the previous electronic medical record. Review of this provided care plan, which was noted to be active and dated 3/19/24, revealed no identification of the problem that the resident distrusted new staff members due to mental illness and that his could contribute to refusal of care. There were no interventions to direct staff in how to deal with this issue.

On 8/13/24 (Tuesday) Nurse Practitioner # 1 documented she saw Resident # 1 and noted the following information. She was a bedbound resident and was being seen for follow up after living larvae (maggots) had been identified in her right hand/fingers and manually removed. Hygiene care had been provided and an antibiotic ointment applied. Oral antibiotics had been initiated also. At the time NP # 1 saw the resident the resident had no agitation or anxiety and was

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skin to by MDS nurse on 10/08/2024.

Resident #6 is no longer in the building.

Resident #16 is no longer in the building.
How will you identify other residents having the potential to be affected by the same deficient practice?
100% audit was done on 10/1/2024 of all residents by the MDS nurse to ensure that comprehensive care plans were in place for all residents.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
Effective 10/07/2024, following the completion of Omnibus Budget Reconciliation Act (OBRA) required Minimum Data Set (MDS) assessment, the MDS nurse will develop/review and revise a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the assessment.
Administrator will re-educate MDS nurse(s) on the importance of developing and/or revising comprehensive care plan for each resident following the completion of OBRA required assessments. The education also emphasized that; comprehensive care plan should be person-centered with measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in

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at her baseline. There was mild swelling of her right hand fingers, and fingers 3 to 4 were tender to touch. There was no drainage or redness.

Nurse # 1 was interviewed on 8/30/24 at 5:45 PM and reported the following. During the weekend prior to Resident # 1 being seen by the NP on 8/13/24 (Tuesday) and the maggots being found, the resident had been complaining of her hand hurting. She had a contracted hand. The Nurse Aides said the resident would refuse care at times.

The weekend treatment nurse was interviewed on 8/31/24 at 9:30 AM and reported the following information. She (the weekend treatment nurse) saw Resident # 1's hand on 8/11/24 (Sunday) and she cared for a small puncture wound where the resident's fingernails had been against the skin. The resident had refused to have her nails trimmed and cared for. There were no maggots at that time.

Nurse Aide # 2, who had been assigned to care for Resident # 1 on 8/12/24 (Monday), was interviewed on 8/29/24 at 7:47 PM and reported the following information. On 8/12/24 she had been providing care when she saw maggots on the resident and in her bed. Prior to 8/12/24, the resident would at times refuse care to her hand if she did not know the staff member well who was trying to provide care.

NA # 3, who at times cared for Resident # 1, was interviewed on 8/29/24 at 12:40 PM and reported the following information. She had never witnessed maggots in Resident # 1's hand. She did know the resident's hand hurt at times and she would not allow the staff to care for the hand

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the assessment. This education is completed on 10/7/2024 and will be added on the new hire orientation for all new MDS nurses.
Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/07/2024, Administrator, Assistant Administrator, DON and/or ADON will monitor compliance with comprehensive care plan by validating its completion in electronic health records following the completion of OBRA assessment. This monitoring process will be completed twice weekly for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the MDS nurse promptly. This monitoring process will be documented on a Care plan review monitoring tool located in the facility compliance binder.
Effective 10/14/2024, Assistant Administrator and/or MDS nurse will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING ______ B. WING ______	C 09/12/2024

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**

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F 656	Continued From page 91 at times. Resident # 1 was interviewed on 8/29/24 at 8:20 AM and went from topic to topic in her conversation in a rambling manner. At this time of morning the resident was observed to have what appeared as an orange vegetable food item on her gown which appeared similar to soft carrots or sweet potatoes. Interview with NA # 3 directly following this observation made on 8/29/24 at 8:20 AM revealed the resident may have refused to allow the previous shift to change the gown when it was soiled with food. Nurse Practitioner # 1 (NP#1) was interviewed on 9/5/24 at 8:55 AM and reported the following information. She had been called on 8/12/24 and told the resident had maggots on her. She had been informed that there had been approximately 26 maggots removed from her. The resident was considered to be cognitively intact but also had some mental illness. The resident tended to talk to non-existent people at times and when she (NP # 1) tried to talk to Resident # 1 on 8/13/24 the resident was doing so. The resident tended to keep snacks in her room. If she had gotten some food in her hand without adequate hygiene, then flies could have landed on her hand and laid eggs. It did not take long for a fly to do this. The resident tended to not be trusting of staff if she did not know them. This was due to her mental illness. If she had refused care, her distrust of some new staff members may have contributed to refusal of hygiene. The NP felt patience and talking to the resident to develop a trusting relationship could contribute to helping the resident be more receptive to consistent hygiene care.	F 656		

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F 656	Continued From page 92	F 656		

The facility's care plan nurse was interviewed on 8/30/24 at 9:54 AM and reported the following information. He had just started in June 2024 and the other care plan/MDS (Minimum Data Set) assessment nurse was also new and in training. He was not familiar with Resident # 1 and did not know who would have been responsible prior to him for developing a care plan to address the resident's refusal of care due to distrust of staff. He did think that if a resident was refusing care that it should be addressed on the care plan.

2. Record review revealed Resident # 2 was admitted to the facility on 10/27/23. The resident's diagnoses included in part a history of congestive heart failure, a history of spinal stenosis and stroke. The resident also had a diagnosis of peripheral neurofibromatosis (a genetic condition that can lead to multiple skin tumors).

Resident # 2's significant change Minium Data Set assessment, dated 8/22/24, coded the resident as moderately cognitively impaired. The resident was also assessed to be totally dependent on staff for bed mobility, hygiene needs, and bathing needs.

Review of Resident # 2's care plan revealed it had been updated on 7/18/24 to include that the resident required assistance with his activities of daily living due to congestive heart failure and chronic medical conditions. The care plan also noted the resident was incontinent of bladder and bowel, and staff were directed on the care plan to assist the resident with care.

Resident # 2 was interviewed on 8/28/24 at 3:50 PM and reported the following information. The tumors on his back would at times drain and

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bleed. Then he would lie on the sheets in the drainage. Some of the Nurse Aides were very good to clean his back and change his linens. Other Nurse Aides would not wash his back and also tell him the linens were okay and did not need to be changed as they cared for him. That day his current Nurse Aide (NA # 1) was very good, and she had helped change his linens and make sure his back was washed so that he would not have to lie in the drainage.

Resident # 2's responsible party was interviewed 8/28/24 at 1:43 PM and reported the following information. The tumor areas on his back would drain and his linens would become "gross and smelly." He was also supposed to get showers, and this helped when his back was washed in the shower, but that was not being done consistently. It depended on who the staff member was whether his soiled linens would get changed and if his back was washed where the tumors drained.

Nurse Aide # 1 was interviewed on 8/29/24 at 4:40 PM and reported the skin tumors on his back would drain and then mix with sweat. She found his linens the previous day when she cared for him on initial rounds to be bad with the drainage and in need of being changed. She routinely bathed, dried, and powdered his back. She also made sure she changed his linens often but she was aware all of the Nurse Aides did not do that.

Review of Resident # 2's active care plan, dated 7/18/24, revealed no individualized care plan addressing the resident's care of the multiple skin tumors and directions to staff how frequently he needed skin care due to the tumors and the

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F 656	Continued From page 94	F 656		

frequency of his linen changes due to the drainage from the tumors.

The facility's care plan nurse was interviewed on 8/30/24 at 9:54 AM and reported the following information. He was aware Resident # 2 had areas on his back due to his diagnosis of neurofibromatosis. He was also aware the resident was very focused on his back, and that he had requested to have a bath every day because of the areas. It was an oversight on his part not to have included specific care related to this problem on the care plan. He had just started in June 2024 and there was one other care plan nurse who was new also. The other care plan nurse was being trained and therefore there was a lot for him to do. It was his understanding that before he started to work in June 2024 that the care plan nurse position had been vacant for several weeks. He was not sure who had been coordinating and developing the care plans for residents before he arrived in June 2024. At the present time he was trying to catch up on a long list of care plans.

3. Resident # 16 was admitted to the facility on 6/17/24. One of the resident's diagnoses included urinary retention.

Review of Resident # 16's admission Minimum Data Set assessment, dated 6/20/24, revealed the resident an indwelling urinary catheter.

Review of the resident's care plan, dated 8/9/24, revealed no mention of the urinary catheter or the care of the indwelling catheter.

Review of physician orders on 8/29/24 revealed no physician orders for the care of the catheter.

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Interview with Resident # 16's responsible party (RP) on 8/28/24 at 3:29 PM revealed the resident routinely saw a urologist and his indwelling catheter was to be changed every month. This had not been done at the facility when it was due after he was admitted. He felt that the communication was very poor about what needed to be done for the resident's urinary catheter.

The facility's care plan nurse was interviewed on 8/30/24 at 9:54 AM and reported the following information. The care of the resident's indwelling urinary catheter should be addressed on the care plan. He was not familiar with the resident, and he was not sure who had devised his care plan.

4. Resident #6 was admitted to the facility on 7/25/24 with diagnoses including cerebrovascular disease. She discharged to the community on 8/26/24.

Resident #6's admission Minimum Data Set (MDS) assessment dated 7/31/24 revealed she was cognitively intact. She had no mood symptoms or behaviors. She was coded as planning to discharge to the community.

Review of the resident's care plan, dated 8/1/24, revealed no mention of the resident wishing to return to the community or discharge planning goals.

An interview was conducted with Social Worker #1 on 8/29/24 who stated discharge planning goals were not put on Resident #6's care plan. He stated Social Worker #2 worked with this resident and he was unsure why discharge planning was not on the care plan.

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F 656	Continued From page 96 Social Worker #2 was unavailable for interview. The facility's care plan nurse was interviewed on 8/30/24 at 9:54 AM and reported sometimes the facility social workers would place the discharge planning goal on the care plan and sometimes he would not do it.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		10/14/24

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Continued From page 97

by:

Based on record review, staff interview, and family interview the facility failed to include the responsible party in a care plan to address discharge planning (Resident # 6 and # 17) and over all medical care needs (Resident # 16). This was for three of nine sampled residents whose responsible parties were interviewed about medical care at the facility. The findings included:

1. Resident # 16 was admitted to the facility on 6/17/24. Two of the resident's diagnoses included urinary retention and congestive heart failure.

Review of Resident # 16's admission Minimum Data Set assessment, dated 6/20/24, revealed the resident was cognitively impaired and had an indwelling urinary catheter.

Review of the resident's care plan, dated 8/9/24, revealed no mention of the urinary catheter or the care of the indwelling catheter. Review of physician orders on 8/29/24 revealed no physician orders for the care of the catheter. There was no documentation the responsible party had been invited and involved in a care plan meeting.

Interview with Resident # 16's responsible party (RP) on 8/28/24 at 3:29 PM revealed he had never been involved in any type of care plan for the resident. He had concerns regarding how the facility was caring for the resident's indwelling catheter, and also regarding the facility staff failing to obtain labs and weights related to his medical diagnoses as ordered by the physician. The RP felt that the communication was very poor at the facility about what needed to be done for the resident. He thought a care plan session

F 657

F657

What corrective actions will be accomplished for those residents found to be affected by the deficient practice?

Residents #6 and #16 are no longer in the facility.

Resident #17 has a care plan meeting is scheduled to be conducted on 10/08/2024. The Facility invited resident #17, and resident #17□s family member.

How will you identify other residents having the potential to be affected by the same deficient practice?

100% audit was done on 10/7/2024 of all residents in the facility to identify if they had a care plan meeting held in the last 30 days. The audit wad completed by the facility social worker and/or Assistant Administrator. Any resident identified without a care plan involvement in the last 30 days, will have a care plan meeting conducted by 10/14/2024.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Effective 10/07/2024, the facility social worker will utilize OBRA required MDS assessment schedule to set up care plan meeting monthly. Social worker(s) will review the schedule for the upcoming

F 657 Continued From page 98

would help but one had never been arranged for him to attend.

The facility's care plan nurse was interviewed on 8/30/24 at 9:54 AM and reported the following information. The care of the resident's indwelling urinary catheter should be addressed on the care plan. He (the care plan nurse) was new to the facility and had started in June 2024. He was not familiar with Resident # 16 and he was not sure who had devised his care plan. There had been a social worker who was now on leave and who was supposed to be inviting and coordinating families with care plans. He was not sure why Resident # 16's Responsible Party had not been involved in the plan of care.

2. Resident #17 was admitted to the facility on 8/13/2024 with multiple diagnoses some of which included blindness in right and left eyes, dementia, cancer, and Type 2 diabetes.

Documentation on an Admission Minimum Data Set (MDS) assessment dated 8/19/2024 coded Resident #17 as having moderately impaired cognition, range of motion impairment on both sides of upper and lower extremity, occasional incontinence of bladder, and frequently incontinent of bowel.

Documentation on a care plan initiated on 8/14/2024 and revised by the MDS/Care Plan coordinator on 8/20/2024, revealed Resident #17 had a focus area for incontinence of bladder. The interventions included recording bowel movements and referring to occupational therapy as indicated. Documentation on the same care plan revealed a focus area for the resident's blindness. The intervention was for administration

F 657

month and send care plan invitation letter to residents and resident representative to solicit the participation of the resident and the resident's representative(s).

Effective 10/07/2024, facility social worker will be in charge of coordinating care plan meetings that include the participation of the resident and the resident's representative(s) if all practical. The facility social worker will document an explanation in a resident□s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident□s care plan.

Administrator and Assistant Administrator will re-educate MDS nurse and social worker on the importance of developing and/or revising comprehensive care plan for each resident following the completion of OBRA required assessments, and the importance of involving resident and resident representative on care plan development through implementation of care plan meeting process specified above. This education is completed on 10/14/2024 and will be added on the new hire orientation for all new MDS nurses and social workers.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/07/2024, Administrator, Assistant Administrator, DON and/or ADON will monitor compliance with care

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F 657	Continued From page 99 of medications as ordered. An additional focus area on the care plan was for Resident #17's risk for falls with one of the interventions being to remind the resident to use their call light to ask for assistance with activities of daily living. The responsible party (RP) for Resident #17 was interviewed on 8/28/24 at 3:09 PM. Resident # 17's RP reported she had multiple concerns about care issues. These were regarding the resident being placed in a pull up, medications being late, and a lack of response to the call bell. There had never been a care plan meeting to discuss his care, and she did not understand why not. At that point the RP expressed she just wanted Resident #17 to be moved to another facility. An interview was conducted with the facility Social Worker on 8/29/2024 at 2:51 PM. The Social Worker revealed it was his second week in employment at the facility. The Social Worker stated he was unsure who was setting up care plan conferences prior to his employment at the facility. The Social Worker was currently aware of the RP for Resident #17's request, but for insurance reasons it was proving difficult to find alternate placement. The Social Worker stated a care plan conference could be set up, but the RP for Resident #17 just wanted alternate placement for him. An interview was conducted with the MDS/Care Plan coordinator on 8/30/2024 at 9:53 AM. The MDS/Care Plan coordinator stated the Social Worker was notifying residents and family of care plan meetings and setting up discharge planning. The MDS/Care Plan coordinator did not recall creating the care plan for Resident #17 nor did he	F 657	plan involvement by validating completion of care plan meetings following the care plan schedule. This monitoring process will be completed twice weekly for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Assistant Administrator promptly. This monitoring process will be documented on a Care plan involvement review monitoring tool located in the facility compliance binder. Effective 10/14/2024, Assistant Administrator and/or social worker will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.	

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F 657	Continued From page 100 recall attending a care plan meeting for Resident #17. 3. Resident 6 was admitted to the facility on 7/25/24 with diagnoses including cerebrovascular disease. She was discharged to the community on 8/26/24. Resident #6's admission Minimum Data Set (MDS) assessment dated 7/31/24 revealed she was cognitively intact. She was coded as planning to discharge to the community. Review of the resident's care plan, dated 8/1/24, revealed no mention of discharge planning. There was no documentation Resident #6, or the Responsible Party (RP) had been invited and involved in a care plan meeting. An interview with Resident # 6's RP on 8/28/24 at 2:47 PM revealed she had never been involved in any type of care plan for the resident. She stated she was initially told Resident #6 was going to be discharged on 8/17/24 and that did not happen. The RP stated she was contacted on 8/23/24 and was told the resident was going to be discharged on 8/24/24. The RP felt that the communication was very poor at the facility about what needed to be done for the resident. She further stated better planning should have been done by the facility. The facility's care plan nurse was interviewed on 8/30/24 at 9:54 AM and reported the following information. He (the care plan nurse) was new to the facility and started in June 2024. He was not familiar with Resident # 6, and he was not sure who had devised his care plan. There had been a social worker who was supposed to be inviting	F 657		

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F 657	Continued From page 101 and coordinating families with care plans. He was not sure why Resident # 6 or their Responsible Party had not been involved in the plan of care.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 660		10/14/24

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F 660	Continued From page 102 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's	F 660		

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 660	Continued From page 103 discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and resident interview the facility failed to implement an effective discharge planning process for one (Resident #7) of one resident who wished to discharge from the facility. The findings included: Resident #7 was admitted to the facility on 8/19/2024 with multiple diagnoses some of which included Type 2 Diabetes, protein calorie malnutrition, gastrostomy status, and chronic kidney disease stage 3. Documentation in the base line care plan written by the Minimum Data Set (MDS) /Care plan coordinator initiated on 8/20/2024 revealed there was no documentation for Resident #7's discharge plan to return to the community. Documentation on an admission Minimum Data Set (MDS) assessment dated 8/25/2024 revealed Resident #7 was cognitively intact. Resident #7 was coded as previously, prior to current illness, as being independent with self-care, mobility, stairs, and functional cognition. Resident #7 was coded as requiring substantial or maximal assistance for all activities of daily living upon admission to the facility, except for eating, for which he required partial or moderate assistance. An interview was conducted with Resident #7 on an initial tour on 8/28/2024 at 10:24 AM and again on 8/29/2024 at 11:08 AM for follow-up questions. Resident #7 provided the following information.	F 660	F660 What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #7 is no longer in the facility. How will you identify other residents having the potential to be affected by the same deficient practice? 100% audit was done on 10/7/2024 of all residents admitted in the facility for the last 30 days to validate each resident has a completed discharge planning psychosocial assessment in the facility electronic health records by the facility social worker and/or Assistant Administrator. 100% audit was done on 10/7/2024 of all residents in the facility by the Assistant administrator to ensure that each resident has a comprehensive care plan including discharge plan documented on a discharge care plan. Any resident identified without a discharge care plan, the facility social worker will develop the discharge plan of care based on resident□s desires. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Effective 10/07/2024, a facility social worker and/or assistant social worker will complete the discharge psychosocial assessment that include the provision for	

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Resident #7 stated his greatest desire was to go home. Resident #7 acknowledged that when he first arrived at the facility, he required a lot of help and therapy services. Resident #7 stated that he was currently able to walk around, catheterize himself as needed, was eating and drinking on his own, and meeting his own activity of daily living needs. Resident #7 stated he found the food at the facility to be unbearable, but he ate it because he had to. Resident #7 expressed he wanted to return home and no longer sit in the facility watching television. Resident #7 revealed he told a social worker a couple of days ago he wanted to go home but heard nothing back. Resident #7 stated nobody listened when he told them he wanted to go home now.

Documentation in an occupational therapist note dated 8/27/2024, written by the Rehabilitation Services Manager, revealed, "[Resident #7] in bed upon this writer's arrival in room. [Resident #7 informed his writer that [Medical Director] told him yesterday that nursing to remove catheter. [Resident #7] educated on plan of [treatment] and [Interdisciplinary team] made aware of [Resident #7] requesting a [discharge] care plan."

An interview was conducted with the Rehabilitation Services Manager on 8/29/2024 at 11:15 AM. The Rehabilitation Services Manager explained on 8/28/2024 she discussed the request of Resident #7 to go home with the interdisciplinary team during the morning meeting. The Rehabilitation Services Manager explained that home health services and therapy services would have to be set up for Resident #7 to go home, and the facility Social Worker was not in the morning meeting on 8/28/2024 for her to let him know of the request to go home of

F 660

discharge planning section that specify the discharge location for each resident, medical equipment arrangements, and home healthcare arrangements. This assessment will be completed on admission/readmission and quarterly afterward and with any changes in discharge planning.
Effective 10/07/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS), Social worker, Unit coordinators (#1, #2), and/or wound nurse, modified the review process for new admission/readmission to ensure that the review include validation that discharge psychosocial assessment is completed, and discharge care plan is developed for all residents who were admitted to the facility in the last 24 hours or from the last clinical meeting. This process will be incorporated into the daily clinical meeting. Any negative findings will be addressed promptly and documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.
Assistant Administrator will re-educate social worker on the importance of completing discharge planning psychosocial assessment and implement the discharge planning process that focuses on the resident□s discharge goals, with the resident as the active partners for effectively transition to the discharge location. The education also emphasized that; discharge care plan must be developed on admission based on resident□s desires. This education is completed on 10/14/2024 and will be

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F 660	Continued From page 105 Resident #7. The Rehabilitation Services Manager stated she did discuss with the therapy services team what the needs of Resident #7 would be if he were to go home. The Rehabilitation Services Manager indicated it was the facility Social Worker who would have to set up discharge planning for Resident #7 and she indicated she would go directly to the Social Worker to let him know of the request for Resident #7 to go home. An interview was conducted with the facility Social Worker on 8/29/2024 at 2:51 PM. The Social Worker revealed it was his second week in employment at the facility. The Social Worker stated he immediately started discharge preparations for Resident #7 that day (8/29/2024) since it was brought to his attention by the Rehabilitation Services Manager of his desire to go home immediately. The Social Worker stated he was actively setting up home health services and durable medical equipment delivery for Resident #7 for that day (8/29/2024). The Social Worker stated the facility was not holding Resident #7 hostage and revealed Resident #7 cried and hugged him when he found out he was able to go home. An interview was conducted with the MDS/Care Plan coordinator on 8/30/2024 at 9:53 AM. The MDS/Care Plan coordinator stated it was the role of the Social Worker to set up discharge planning.	F 660	added on the new hire orientation for all new social worker. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/7/2024, Assistant Administrator and Social Worker will monitor compliance with discharge planning. This monitoring process will be accomplished by reviewing the completion of discharge planning psychosocial assessment for all new admission/readmission and quarterly. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 10/14/2024, Assistant Administrator and/or social worker will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		10/14/24

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F 677	Continued From page 106 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with resident, family, and staff the facility failed to ensure a resident received assistance with incontinent care. This was for one (Resident # 2) of four residents reviewed for activity of living needs being met. The findings included: Record review revealed Resident # 2 was admitted to the facility on 10/27/23. The resident's diagnoses included in part a history of congestive heart failure, a history of spinal stenosis and stroke. Resident # 2's significant change Minium Data Set assessment, dated 8/22/24, coded the resident as moderately cognitively impaired. The resident was also assessed to be totally dependent on staff for bed mobility, hygiene needs, toileting needs, and bathing needs. He was assessed to be frequently incontinent of bowel and bladder. Review of Resident # 2's care plan revealed it had been updated on 7/18/24 to include that the resident required assistance with his activities of daily living due to congestive heart failure and chronic medical conditions. The care plan also noted the resident was incontinent of bladder and bowel, and staff were directed on the care plan to assist the resident with care. Resident # 2 was interviewed on 8/28/24 at 3:50 PM and reported the following information. He often had to wait to be changed when he was incontinent. There had been a recent incident	F 677	F677 What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #2 was assessed by the Unit Coordinator #1 on 10/7/2024 for any signs or symptoms of distress for missing assistance for activities of daily living (ADL care). No signs or symptoms of distress noted for resident #2 Identification of other residents having the potential to be affected by the same deficient practice: 100% observation of residents in the facility completed on 10/07/2024 by DON, ADON, Unit coordinator #1, #2 and/or scheduler to validate all residents receives assistance of daily living care including incontinent care. This audit is documented on ADL audit tool located in a facility compliance binder Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 10/07/2024 facility will ensure that any 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. These systemic changes will be accomplished by implementing the following measures: Effective 10/07/2024, facility scheduler will	

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during which he waited for hours and had soiled himself with both urine and stool. He routinely called his sister to let her know when he had requested help and any problems getting help.

Resident # 2's responsible party was interviewed 8/28/24 at 1:43 PM and reported the following information. Resident # 2 often had to wait to be changed. He would call her about the situation, and she would take notes. There had been an incident on 8/18/24 when he had called her around 8:30 AM letting her know he was waiting to be changed. He had soiled himself. He called her that same day at 4:00 PM letting her know that they had just changed him at 3:00 PM. They had not had enough staff to change him.

On 9/4/24 at 3:48 PM the facility corporate Nurse Consultant reported that the census on the 300/400 halls was 66 on the date of 8/18/24.

Nurse Aide # 8 was interviewed on 9/3/24 at 7:20 PM and reported the following information. On 8/18/24 there were only two Nurse Aides for the day shift for the 300 hall and 400 hall. She had been assigned to Resident # 2 and what he reported regarding not receiving incontinent care was true. The Nurse Aide reported that there were so many residents for whom they had to care that it was just impossible to get to Resident # 2 sooner than she did. In addition to making rounds for hygiene and incontinent care, the two Nurse Aides had to pass out trays and feed residents for the breakfast and lunch meal.

Interview with the corporate Nurse Consultant on 8/31/24 at 12:00 PM revealed the facility was currently working on staffing and trying to hire quality employees after ending employment with

F 677

ensure adequate staffing necessary to assure each resident in need of ADL assistance to maintain good nutrition, grooming, personal, and oral hygiene receive such services in a timely manner.

All nurses and CNAS will be educated by the DON, ADON, Unit Coordinator (#1, #2) on answering call bells in a timely manner, and provide necessary services to maintain good nutrition, grooming, and personal and oral hygiene, as well as incontinent care for all residents who are unable to carry out activities of daily living. This education will be completed by 10/14/2024. Any licensed staff not educated by 10/14/2024, will not be allowed to work until educated.
Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:
Effective 10/14/2024, the medical records coordinator will audit, and interview 3 residents chosen from each unit, twice weekly, and ask them if they have had their call bells answered in a timely manner and received ADL care to include incontinent care if applicable. This will be done for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained.
Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of

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F 677	Continued From page 108 multiple administrative staff members in recent weeks.	F 677	compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Emergency Medical Services (EMS) interview, family interview, and physician interviews, pharmacy interviews the facility staff were made aware Resident #21 had a blood glucose level of 33 milligrams/deciliter (mg/dL); the facility failed to administer Glucagon (Glucagon is a manmade version of a hormone made by the pancreas that raises blood glucose levels) per standing orders; and failed to effectively respond to a medical emergency of hypoglycemia. Upon EMS arrival Resident #21 had a blood glucose level of 38 and was unresponsive. The hospital records indicated Resident #21 was profoundly hypoglycemic. (Hypoglycemia is a medical condition in which the body's blood glucose level falls too low for bodily functions to continue. Severe hypoglycemia may trigger loss of consciousness or seizures.) Additionally, Resident #22 had a blood glucose	F 684	F684 Corrective actions accomplished for those residents found to be affected by the deficient practice: 1. Resident #16 no longer in the facility, no other actions taken for resident #16 2. Resident #21 was assessed by the Assistant Director of Nursing on 09/06/2024 for any clinical signs of hypoglycemia. No signs of hypoglycemia were noted. 3. Resident #22 is no longer in the facility. No other actions taken for resident #22. Identification of other residents having the potential to be affected by the same deficient practice: Clinical assessments of all current	10/14/24

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F 684	Continued From page 109 level registering over 400 mg/dL over two days; the facility failed to assess and monitor the resident in order that a physician who oversaw the resident's care be accurately appraised of her medical status; and the facility failed to effectively respond to a medical emergency when Resident #22 was found to be nonresponsive by a physical therapy staff member hours before EMS was called. Resident #22 was found with an elevated heart rate of 140 beats per minute (bpm) (a typical resting heart rate for adults is between 60 and 100 bpm), respirations in the 40s breaths per minute (a normal respiratory rate is between 12 and 20 breaths per minute), and with a continued reading of a blood glucose level more than 400 mg/dL at time of transport by EMS. At the time of ED (emergency department) physician assessment, Resident # 22 was diagnosed with sepsis and hyperglycemia. (Hyperglycemia is a medical condition in which the body's blood glucose level is higher than normal. High blood glucose happens when the body has too little insulin or when the body can't use insulin properly.) The facility failed to implement physician ordered laboratory tests and obtain weights used to assess Resident #16's medical condition. This was for three (Resident #21, #22, and #16) of five residents reviewed for a change in medical condition. Immediate jeopardy began on 6/28/2024 when Resident #21 was identified as having a blood glucose reading of 33 mg/dL and the facility failed to administer Glucagon per physician standing orders. Immediate jeopardy began on 7/10/2024 when Resident #22 was identified as having a blood glucose reading of over 400 mg/dL and the facility failed to effectively assess and implement interventions. Immediate Jeopardy was removed	F 684	residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention. The clinical assessment focused on resident�s vital signs to include, blood pressure reading, pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated. 100% audit of all current resident�s blood glucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a resident with episodes of hypoglycemia and/or hyperglycemia that was not addressed appropriately in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents� choices. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered.	

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on 9/9/2024 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. Example #3 for Resident #16 will be cited at a lower scope and severity level of D.

Findings included:

1. Resident #22 was originally admitted to the facility on 8/2/2023 with multiple diagnoses some of which included dementia, type 2 diabetes mellitus, schizoaffective disorder, major depressive disorder, and hypertension. Resident #22 was readmitted to the facility on 6/21/24 after a hospitalization for the diagnoses of sepsis, urinary tract infection, and hydronephrosis. (Hydronephrosis is a medical condition characterized by excess fluid in a kidney due to blockage in the tube that connects the kidney to the bladder.)

Documentation on a quarterly Minimum Data Set assessment dated 6/24/2024 revealed Resident #22 was assessed as having adequate hearing and vision with clear speech. Documentation on the same assessment indicated Resident #22 was usually understood and usually had the ability to understand others. Resident #22 was coded as having the diagnosis of type 2 diabetes mellitus and received insulin injections for 7 days of the assessment period.

Documentation on the care plan initiated on 6/22/2024 revealed a care plan description of Resident #22's risk for hypo/hyperglycemia and a diagnosis of diabetic retinopathy relative to a

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100% audit of all current residents with orders for daily weights completed on 10/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other resident who missed daily weights in the last seven days to validate daily weight was obtained as ordered. Any resident(s) identified with missing daily weight, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered.

Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:

Effective 09/07/2024, facility employees will ensure residents received necessary care to include assessing, monitoring, addressing a change in condition, identify the seriousness of a change in condition, and recognize the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. This systemic modification will be accomplished by implementing the following measures: Effective 09/07/2024, licensed nurses will oversee care and services for each resident in the facility. The Nurse will be informed at the beginning of the shift, through the daily schedule, of his/her responsibility to oversee certified medication aide(s) if any.

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diagnosis of diabetes mellitus. One of the interventions was to observe signs and symptoms of hypo/hyperglycemia such as sweating, tremor, pallor, nervousness, headache, double vision, confusion, and or lack of coordination. Additional interventions were to perform blood glucose monitoring and medication/insulin as ordered.

Documentation in a physician order dated 6/22/2024 revealed Resident #22 was ordered to receive Novolog insulin solution to be injected subcutaneously (applied under the skin) three times day at 8:00 AM, 12:00 PM, and 4:00 PM per the following sliding scale: If the blood glucose level was 201 to 250 administer 4 units; 251 to 300 administer 6 units; 301 to 350 administer 8 units; 351 to 400 administer 10 units; greater than 400 call the physician. Novolog is a fast-acting insulin used to treat high blood glucose for people with diabetes.

Documentation in a physician order dated 6/22/2024 revealed Resident #22 was ordered to receive 5 units of Semglee insulin solution to be injected subcutaneously one time a day at 8:00 PM for hyperglycemia. Semglee is a long-acting insulin used to treat high blood glucose levels for people with diabetes.

Documentation on the July Medication Administration Record (MAR) for Resident #22 revealed on 7/9/2024 the blood glucose level was 399 and Medication Aide (Med Aide) #5 administered ten units of insulin at 6:22 PM.

Med Aide #5, an agency employee, was interviewed on 9/5/2024 at 1:08 PM and revealed the following information. Med Aide #5 confirmed she did take the blood glucose reading of 399 on

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Effective 09/07/24, Director of Nursing, Assistant Director of Nursing, Unit Coordinator (#1 or #2), Weekend Supervisor, and/or Scheduling Coordinator will be responsible to update daily schedule for nursing staff (licensed nurses, medication aides, and certified nursing aides). The daily schedule will inform each nursing staff of their assignment and responsibilities to include responsibility for licensed nurses to oversee medication aides (if any).

The Facility Administrator will educate Director of Nursing, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator. The education focused on the importance of ensuring a daily nursing schedule is completed and indicate the responsibility of each nursing staff to include the responsibilities of the licensed nurse to oversee the medication aides. This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24 will not be allowed to work until educated. The Director of Nursing will complete this education for any newly hired, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator during the orientation process effective 9/8/2024.

Effective 09/07/2024 the assigned licensed nurse will be responsible to provide necessary care to include assessing, monitoring, addressing a change in condition, identifying the

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7/9/2024 and that she did not administer insulin to Resident #22. Med Aide #5 did not recall who the licensed nurse was who was assigned to help her perform medication administration tasks out of her scope of practice on 7/9/2024. Med Aide #5 explained when she put the blood glucose reading into the electronic MAR, the administration of the insulin would also incorrectly go under her name. Med Aide #5 indicated she had to trust that the licensed nurse, to whom she reported the blood glucose level of Resident #22, would administer the correct insulin dose, document the administration, and notify a physician of any concerns if needed.

Documentation on the July MAR revealed Nurse #4 administered Semglee insulin as ordered to Resident #22 on 7/9/2024 at 8: 24 PM.

There was no documentation on the July MAR Resident #22 had a blood glucose level taken or received Novolog insulin as ordered at 8:00 AM on 7/10/2024.

Med Aide #4, an agency employee, was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 revealed the following information. On the morning of 7/10/24 she was assigned for the 7:00 AM to 7:00 PM shift to the hallway which Resident #22 resided. Med Aide #4 was told Nurse #4 took care of administering medications for several people during the 7:00 PM to 7:00 AM shift ending on 7/10/2024. Resident #22 was one of those people who Nurse #4 told Med Aide #4 she had already administered the morning medications to. Med Aide #4 stated she expected Nurse #4 to document on the MAR the medications she was told had already been administered as an explanation for why there was

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seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents� choices for their assigned residents, and/or those assigned to the medication aide under the nurse�s supervision.

Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident�s medical records, and inform a nurse immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents� choices.

Effective 09/07/2024, facility licensed nurses on duty will administer medication related to hypoglycemia and/or hyperglycemia, including glucagon for low blood sugar, and/or insulin for high blood glucose, based on physician orders and document the administration of such medication in each resident�s clinical record.

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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no documentation of the Novolog insulin for Resident #22 at 8:00 AM on 7/10/2024.

Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered 10 units of Novolog insulin on 7/10/2024 at 1:43 PM to Resident #22, one hour and 43 minutes after the scheduled administration time.

There was no documentation on the July MAR Resident #22 had a blood glucose level taken or was administered Novolog insulin as ordered at 4:00 PM on 7/10/2024.

Med Aide #4, an agency employee, was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 relayed the following information. Med Aide #4 explained that she could not remember which licensed nurse was assisting her on 7/10/2024 and confirmed she did not administer Novolog insulin to Resident #22 on 7/10/2024 at 1:43 PM. Med Aide #4 thought the licensed nurse, assisting her on 7/10/24, was Unit Manager #2. On 7/10/2024 the blood glucose level for Resident #22 read as "HI" or above 400 on the glucose monitor. (A reading of "HI" on a glucometer means the reading is above the level readable by the glucometer.) The licensed nurse who was assisting Med Aide #4 was told the blood glucose monitor was reading above 400 and the physician needed to be called. The licensed nurse told Med Aide #4 the physician ordered 12 units of Novolog insulin to be administered to Resident #22 and to keep checking the blood glucose level every hour. Med Aide #4 kept checking the blood glucose level every hour and reported to the licensed nurse the reading was still registering as above 400 mg/dL. Med Aide #4 thought the

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Effective 09/07/2024, facility Medical Director approved the protocol for low and high blood sugar. The protocol includes, (in part), residents who are unresponsive and with low blood glucose (less than 60) will receive glucagon injection, administered by a licensed nurse, blood sugar will be rechecked within ten minutes, if blood sugar remain less than 60, and/or resident remain unconscious facility staff will call 911. This protocol is implemented effective 09/07/2024.
Effective 09/07/2024, residents with blood glucose over 400 will receive 10 units of fast acting insulin, (Humalog or Novolog), blood glucose will be rechecked within 30 minutes, or per physician order, after the administration of insulin, if blood glucose remains over 400, resident□s physician will be notified for further evaluation and/or treatment. This protocol is implemented effective 09/07/2024.
Effective 09/07/2024, facility employees, including medication aides on duty, will utilize phone intercom communication method and announce code blue for any medical emergency to include but not limited to resident change in condition that require clinical support.
Effective 09/07/2024, facility clinical staff, to include licensed nurses, certified medication aides, certified nursing aides, and any other medical/clinical trained professionals will respond to the code blue announcement and go to the specified location for assistance. Licensed nurse will aid including assessing, monitoring, addressing a change in condition, identifying the seriousness of a

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licensed nurse was going to document everything and take care of the 4:00 PM scheduled Novolog insulin administration on 7/10/2024 because of the blood glucose readings that were over 400 mg/dL, requiring a physician to be involved.

Unit Manager #2 was interviewed on 9/10/2024 at 8:21 AM. Unit Manager #2 revealed the following information. Unit Manager #2 did recall Med Aide #4 contacting her about an elevated glucose level for Resident #22 on 7/10/2024. Unit Manager #2 revealed she assessed Resident #22 and thought she was dehydrated but was arousable and able to drink fluids. Unit Manager #2 stated she was very busy on 7/10/24, in addition to being the unit manager, the only registered nurse in the building, doing wound care, and admitting multiple residents, leaving her with little time for adequate coverage of the Med Aides in the building. Unit Manager #2 revealed she thought she sent a text to the physician for Resident #22 informing him of the elevated blood glucose levels on 7/10/2024. Unit Manager #2 stated she trusted the judgement of Med Aide #4 and felt she communicated effectively if she needed any assistance. Unit Manager #2 could not recall specifically what interventions were put in place on 7/10/2024 other than administration of insulin and fluids but would trust the recollections of Med Aide #4. Unit Manager #2 revealed she kept a small notebook with notes on which residents she had to go back and complete documentation on as a late entry. Unit Manager #2 thought perhaps Resident #22 having elevated blood sugars was one of those residents and she forgot to go back and document.

Documentation on the July MAR revealed Nurse #4 administered Semglee insulin as ordered to

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change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents□ choices.

Effective 09/07/2024, a licensed nurse will remain with a resident with a change in condition that requires emergency medical attention until the emergency medical services (EMS) team arrived for proper monitoring and assessment of the resident.
Effective 10/08/2024, licensed nurse on duty will obtain daily weight per physician order and document in each resident electronic health record as ordered.
Effective 10/08/2024, revised laboratory tracking tool implemented to ensure each ordered laboratory is completed per orders. Unit manager will review the laboratory tracking log in a daily clinical meeting to validate all ordered labs are obtained per order.
100% education of all licensed nurses and Medication aides, to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to:
1. The importance of administering medication to include insulin, glucagon, and other medications per physician order.
2. The importance of ensuring each resident is assigned to a licensed nurse to

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Resident #22 on 7/10/2024 at 10:56 PM.

There was no documentation in the electronic medical record of Resident #22 that any additional interventions were taken for the elevated blood glucose reading on 7/10/2024.

There was no documentation on the July MAR Resident #22 had a blood glucose level taken or was administered Novolog insulin as ordered at 8:00 AM on 7/11/2024.

The facility nursing schedule dated 7/11/2024 indicated Nurse #7 was assigned to the hallway for which Resident #22 resided for the 12 hour "day shift (7:00 AM to 7:00 PM)."

Nurse #7 was interviewed on 9/5/2024 at 2:37 PM. Nurse #7 stated she was an agency nurse who only worked at the facility on one occasion and that was 7/11/2024. Nurse #7 stated she did not recall what hall she was assigned to. Nurse #7 stated when she arrived at 7:00 AM on 7/11/2024, the scheduler handed her a stack of paper MARs and told her to go to the hall to begin the medication pass. Nurse #7 explained she was told she would not have access to the electronic medical record system. Nurse #7 revealed it was "chaos", but she stayed. Nurse #7 further explained that at 2:30 PM she was approached by the Interim Director of Nursing (DON) with the electronic medical record system login information she needed and another stack of papers for a new admission she was expected to process. Nurse #7 said she handed the new admission paperwork back to the Interim DON and told her she wasn't doing it. Nurse #7 revealed she had never returned to the facility.

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oversee his/her care including provision for assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents□ choices.
3. The importance for each medication aide to be aware of their assigned licensed nurse at the beginning of their shift (through the daily schedule that will indicate the nurse who is responsible to oversee them)
4. The use of code blue for all medical emergencies through telephone intercom system
5. The implementation of hypoglycemia protocol for unresponsive residents using glucagon for low blood sugar.
6. The implementation of hyperglycemia protocol includes administration of fast acting insulin and rechecking blood sugar within 30 minutes and notifying physician for any other orders.
7. The importance of calling 911 for medical emergencies that require medical attention at the acute care center. (The education emphasized that any staff member can call 911 when indicated.)
8. Importance for a licensed nurse to remain with a resident until emergency medical services (EMS) arrived.
9. The importance of documenting blood glucose findings in resident□s medical records.
10. For medication aides, the education also covered the importance to report to

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Med Aide #4 was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 stated she was assigned on 7/11/2024 for the 7:00 AM to 7:00 PM shift to another hall next to the hall which Resident #22 resided. Med Aide #4 revealed everything was "a mess" on the hallway which Resident #22 resided because there was an agency nurse (Nurse #7) who was trying to figure out the paper MAR and she was not giving medications. Med Aide #4 revealed the agency nurse (Nurse #7) left and was put on the do not return list.

Documentation on the July MAR revealed Med Aide #4 obtained a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 11:47AM to Resident #22.

Documentation on a physical therapy treatment encounter note for Resident #22 written by Physical Therapy Assistant (PTA) #1 on 7/11/2024 at 3:58 PM revealed, "PTA facilitated that [Resident #22] get [out of bed] for the purpose of attempting goals. [Resident #22] responded [by demonstrating] extreme lethargy, incoherent mumbling, [nonresponsive] pupils/eye movement to bright light. PTA attempted to have [Resident #22] sit [on edge of bed] with [Resident #22 [demonstrating] inability to arise from sleep/difficulty to hold head. Nursing [Med Aide #4], DON, [Physical Therapist/Occupational Therapist] notified regarding [Resident #22's] decrease in status. Continue [with plan of care.]"

An interview was conducted with PTA #1 on 9/6/2024 at 4:45 PM. PTA #1 revealed the following information. PTA #1 stated she did not recall the exact time she went to see Resident #22 on 7/11/2024. PTA #1 confirmed she found Resident #22 in a nonresponsive condition on

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the charge nurse immediately any blood glucose level less than 60, greater than 200 or based on the physician order.
11. The education also covered on the importance of obtaining daily weights and laboratory tests as ordered.
This education will be completed by 10/14/2024. Any licensed nurses and/or medication aide not educated by 10/14/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/7/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the monitoring process to ensure residents received necessary care to include assessing, monitoring, addressing a change in condition, identify the seriousness of a change in condition, and recognize the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents□ choices. This monitoring process will be accomplished by implementing the following measures:
Effective 10/08/2024, the Director of

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F 684	Continued From page 117 that day, so she went to the Med Aide on the hall, the interim DON, the Physical Therapist, and Occupational therapist to let them know of her concern for Resident #22. Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 4:51 PM. Med Aide #4 was interviewed on 9/6/2024 at 1:54 PM. Med Aide #4 confirmed she took the blood glucose readings for Resident #22 on 7/11/2024 at 11:47 AM and 4:51 PM. Med Aide #4 revealed that some of the blood glucose readings for Resident #22 were actually registering as HI or over 400 mg/dL while at least one of the readings she documented on the MAR on 7/11/2024 was actually 400 mg/dL. Med Aide #4 revealed the MAR did not allow Novolog insulin to be checked off as administered unless an actual number was entered into the MAR for the blood glucose reading. Med Aide #4 stated she had to put in 400 mg/dL although the reading may have been over 400 mg/dL. Med Aide #4 confirmed she told the licensed nurse who was assisting her on 7/11/2024 for the 12:00 PM and 4:00 PM administration time for the Novolog insulin, that the blood glucose levels were continuously HI. Med Aide #4 explained the licensed nurses were going into the MAR after she documented the blood glucose reading and using her login credentials to document the administration of insulin. Med Aide #4 was told by the licensed nurse on 7/11/2024 the physician had been contacted and ordered for Resident #22 to be monitored. Med Aide #4 did not recall who the licensed nurse was. Med Aide #4 confirmed PTA #1 informed her of concerns of the lack of	F 684	Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the monitoring process to ensure residents with orders for daily weights and laboratory test orders are completed as ordered, by reviewing the MAR for completion of daily weights and laboratory tracking tool for ordered labs obtained in the last 24 hours or from the last clinical meeting. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON, ADON and/or Unit Coordinator #1 or #2 promptly. Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review daily nursing schedule to validate that a licensed nurses was designated to oversee care and services for each resident in the facility, and validate the daily schedule indicate a name of a nurse responsibility to oversee certified medication aide(s) if any. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON, ADON and/or Unit Coordinator #1 or #2 promptly. This monitoring process will be documented on a blood glucose monitoring tool located in the facility compliance binder. Effective 10/07/2024 the Director of Nursing, Assistant Director of Nursing,	

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F 684	Continued From page 118 response from Resident #22. Med Aide #4 stated she did tell the licensed nurse of what PTA #1 had said. Med Aide #4 stated she informed Unit Manager #2 and sent a text message to the interim DON about the continued blood glucose readings of over 400 mg/dL for Resident #22. Med Aide #4 stated she got a text message back from the interim DON that she "would take care of it." Med Aide #4 stated that in report at the end of her shift on 7/10/24 and 7/11/24 she let Nurse #4 know Resident #22 was continually having blood glucose readings of over 400 mg/dL. Med Aide #4 indicated Nurse #4 did not seem to care, telling her that on the shift, 7:00 PM to 7:00 AM, when Nurse #4 worked, the blood glucose readings for Resident #22 were in the 200's mg/dL. Med Aide #4 stated, "It just didn't make any sense to me but only the nurses can call the doctor." An interview was conducted with the responsible party (RP) for Resident #22 on 9/3/2024 at 3:42 PM and the following information was provided. On 7/8/2024 the RP checked on Resident #22 before going out of town and she was okay. The RP heard nothing all week from the facility. On 7/11/24 around 7:30 PM to 8:00 PM she saw she had several missed calls on her phone. She then picked up on the next one. It was from a private number. The person on the phone did not identify themselves but told the RP, " You need to come now and check on your mother. It is an emergency. She needs to be sent out." The RP did not know what was going on because the facility did not notify her that Resident #22 was sick. The RP called another family member who was local to the facility and asked him to go to the facility to see Resident #22. The family member arrived at the facility around 8:30 to 8:45 PM to	F 684	and/or Unit Coordinators (#1, #2) will review medication administration records for all residents with orders for blood glucose, all residents with orders for daily weights, ensure Licensed nurses obtained daily weights as ordered, reviewed blood glucose outside the physician ordered parameters and provide necessary care to include assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices for their assigned residents, and/or those assigned to the medication aide under the nurses supervision. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON, ADON and/or Unit Coordinator #1 or #2 promptly. This monitoring process will be documented on a blood glucose monitoring tool located in the facility compliance binder. Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review any occurred medical emergency that happened in the last 24 hours or from the last held clinical meeting to validate employees followed the proper protocol to include utilizing phone intercom communication method and announce code blue for any medical emergency to	

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F 684	Continued From page 119 find Resident #22 was not responding. Nurse #4 walked into the room with a blood glucose monitor and said the doctor ordered Resident #22 to receive insulin, to monitor her blood glucose level, and call the doctor back in two hours. Since Resident #22 was not responding the family member insisted that Resident #22 be sent to the emergency room and finally Nurse #4 called emergency medical services (EMS). Later that night the interim DON called the RP wanting to know who had called her from the facility to let her know Resident #22 was not well. The RP stated she did not know who the anonymous phone caller was, but she was grateful she was contacted as it may have saved the life of Resident #22. The RP talked to the (former) Administrator about her concerns and the (former) Administrator informed the RP that the facility had learned that a physical therapy staff member had noted a change in the resident earlier that day. The (former) Administrator maintained that they did not have to let the family know if Resident #22 had elevated blood glucose levels, which did not make sense to her. If she had known that Resident #22's blood glucose levels were running high for several days she would have wanted her sent to the hospital to be checked. Documentation in the physician orders revealed an order dated 7/11/2024 at 7:00 PM for Resident #22 to be administered ten units of Humalog insulin solution to be injected subcutaneously one time only for a blood glucose exceeding 400 mg/dL and contact the physician in two hours. Humalog insulin is a fast-acting insulin which is absorbed quickly and starts working in about 15 minutes after injection to lower blood glucose levels.	F 684	include but not limited to resident change in condition that require clinical support, and validate clinical staff, to include licensed nurses, certified medication aides, certified nursing aides, and any other medical/clinical trained professionals will responded to the code blue announcement and go to the specified location for assistance, and a a licensed nurse will remain with a resident with a change in condition that requires emergency medical attention until the emergency medical services (EMS) team arrived for proper monitoring and assessment of the resident. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON, ADON and/or Unit Coordinator #1 or #2 promptly. This monitoring process will be documented on a F684 monitoring tool located in the facility compliance binder. Effective 10/07/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	

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There was no documentation on the July MAR that the order for Humalog insulin was administered to Resident #22 on 7/11/2024 after 7:00 PM.

Documentation on the July MAR revealed Nurse #4 administered Semglee insulin to Resident #4 on 7/11/2024 at 8:58 PM.

Documentation in the physician orders revealed an order dated 7/11/2024 at 9:00 PM for Resident #22 to be administered ten units of Novolog insulin solution subcutaneously one time for blood glucose exceeding 400 mg/dL and contact the physician in two hours.

There was no documentation on the July MAR that the one-time order for Novolog insulin was ever administered to Resident #22 on 7/11/2024 after 7:00 PM.

There was no other documentation in the electronic medical record of any vital signs taken of Resident #22 on 7/11/2024.

Documentation in the nursing notes for Resident #22 dated 7/12/2024 at 9:48 AM by Nurse #4 revealed, "Physician contacted due to blood glucose exceeding 400 [mg/dL] and order received from physician to administer 10 [units] of Humalog or Novolog and report back after 2 hours. After 2 hours, resident blood [glucose] reading still exceeded 400 [mg/dL] and physician made aware of results. Family arrived and RP requested for resident to be sent to [emergency room] for evaluation. Physician made aware and order received to send resident to [emergency room]. DON made aware."

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F 684	Continued From page 121 An interview was conducted with Nurse #4 on 9/5/2024 at 6:04 PM. Nurse #4 relayed the following information and timeline of events for Resident #22 on the evening of 7/11/2024. Nurse #4 started her 7:00 PM to 7:00 AM shift at 7:00 PM on 7/11/2024. Nurse #4 received the information in a nursing report from Med Aide #4 that the blood glucose level of Resident #22 was above 400 mg/dL on the 4:00 PM medication pass. Nurse #4 denied she had any knowledge of the blood glucose level of Resident #22 being at or above 400 mg/dL for several shifts. Nurse #4 stated she assessed Resident #22 and took her vital signs at the start of her shift. Nurse #4 revealed the blood glucose level of Resident #22 was registering as HI or over 400 mg/dL on the glucometer, a device to measure blood glucose levels. Nurse #4 revealed the vital signs of Resident #22 were fine, so she called the on-call physician. Nurse #4 stated she received an order from the physician to administer 10 units of fast acting insulin to Resident #22 and call the physician back in two hours. Nurse #4 stated she went back to check on Resident #22 again at 9:00 PM and all her vital signs were fine. Resident #22 did not have a temperature, elevated blood pressure, or an elevated heart rate. Nurse #4 stated her blood glucose level was still registering as HI or above 400 mg/dL on the glucometer. Nurse #4 was adamant Resident #22 was fine and was responsive. Nurse #4 related that when she pricked the finger of Resident #22 with the lancet, the resident looked at her and rolled her eyes. Nurse #4 stated the family of Resident #22 arrived at the facility stating they received a phone call from an unknown caller telling them something was wrong with Resident #22, and she needed to be sent to the emergency	F 684		

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F 684	Continued From page 122 room. The family of Resident #22 looked at Resident #22 and demanded she be sent to the emergency room. Nurse #4 stated she did not know who called the family because the breathing and vital signs for Resident #22 were normal. Nurse #4 reported she was about ready to call the physician because of the elevated blood glucose reading, so she called the physician, and the physician agreed Resident #22 could be sent out per the family wishes. Nurse #4 relayed that she did all her documentation for the residents at the end of her shift so that all the events of the shift for each resident could be documented, for an explanation for why her nursing note for Resident #22 was dated 7/12/2024, the day after Resident #22 discharged from the facility. An interview was conducted with the interim DON on 9/5/2024 at 1:58 PM. The interim DON stated she was not made aware of any concerns with the blood glucose levels of Resident #22 until the RP called her on the evening of 7/11/2024 at approximately 8:00 PM or 8:30 PM. The interim DON was told by the RP of a phone call she received from a facility staff member telling her Resident #22 was very ill and needed to be sent to the hospital. The interim DON relayed she called Nurse #4 and was told Resident #22 was still at the facility and was fine. The interim DON further revealed Nurse #4 had explained the following interventions for Resident #22. An assessment had been completed by Nurse #4 revealing an elevated blood glucose level, lethargy, vital signs were fine, the physician was called for orders, and Resident #22 was responsive. The interim DON stated she knew the blood glucose level of Resident #22 was high in the moment on the evening of 7/11/2024 but she was not aware the blood glucose level had	F 684		

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been HI over several shifts.

An interview was conducted with MD #2, the physician for Resident #22, on 9/9/2024 at 1:12 PM. MD #2 stated he could not recall if he was notified of the elevated blood glucose levels of Resident #22 on 7/9/2024, 7/10/2024, or 7/11/2024. MD #2 explained that if he had been notified of elevated blood glucose levels for Resident #22 during normal business hours, he would have ordered a change in the amount of fast-acting insulin to be administered and requested a call back if there was no change after continuous monitoring of the resident. MD #2 indicated that if those orders did not exist on 7/10/2024 or 7/11/2024 during the day shift then it was likely he was not notified. MD #2 stated he did not recall receiving a phone call on the evening of 7/11/2024 from Nurse #4, but he received phone calls of that type routinely making it difficult to recall a specific phone call of that type for a resident. MD #2 stated that a blood glucose level of 400 mg/dL was "not good," but having a blood glucose level of 400 mg/dL was an isolated event for this resident making it likely an underlying medical condition was occurring for which he would have had to figure out.

Documentation on an Emergency Medical Services (EMS) report dated 7/11/2024 revealed 911 was called at 9:17 PM and arrived at room of Resident #22 at 9:37 PM. The following information was revealed in the EMS report. Upon arriving at the scene, the facility staff stated Resident #22 had been having an elevated blood glucose level all day and had been alert but not acting like herself. The facility staff also told EMS they had been giving Resident #22 insulin as instructed by the resident's physician with no

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changes in the reading level of HI on the glucose monitor. EMS noted Resident #22 had a glucose reading of HI on their glucose monitor as well. EMS documented Resident #22 as having a heart rate of 140 with respirations in the 40s. Once in the ambulance, Resident #22 remained unresponsive.

Documentation on a hospital record dated for a 7/11/2024 admission revealed Resident #22 was diagnosed with sepsis, hyperglycemia, altered mental status, acute renal failure, dehydration, and a urinary tract infection in the emergency room. Resident #22 was discharged from the hospital on 7/24/2024 into the care of the RP with home health services, per the RP's request.

2. Resident # 21 was originally admitted to the facility on 2/8/21. The resident's diagnoses included in part a diagnosis of diabetes, dementia, and a history of heart attack and cancer.

Review of Resident # 21's 4/12/24 quarterly Minimum Data Set assessment revealed the resident was cognitively impaired. He was able to clearly speak and make himself understood. He was also able to eat with supervision only. The resident was also coded to be a diabetic and had required insulin for seven days in the assessment period.

Review of June 2024 monthly orders and the June 2024 MAR (medication administration record) revealed the following:

Resident # 21 had an order, which originated on 3/25/23, for Humalog 100 units/ml give 5 units under the skin with breakfast. (Humalog is a

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fast-acting insulin).

Resident # 21 had an order, which originated on 11/16/23, for Humalog 100 units/ml give 10 units under the skin every day at 12 PM.

Resident # 21 had an order, which originated on 11/16/23, for Humalog 100 units/ml give 7 units under the skin every day at 4:30 PM.

Resident # 21 had an order, which originated on 4/18/24, for Levemir 70 units every hour of sleep. (Levemir is a long acting insulin).

Additionally Resident # 21 had orders for blood glucose checks and sliding scale insulin coverage with Humalog Insulin four times per day. The sliding scale insulin dosage was noted be as follows: 201-250 4 units; 251-300 6 units; 301-350 8 units; 351 to 400 10 units; call MD for greater than 400. According to the June 2024 MAR the blood glucose checks were scheduled for 6:00 AM; 11:30 AM; 4:30 PM; and 9:00 PM. The resident's MAR was blank for the reading on 6/28/24 at 6:00 AM.

Resident # 21 also had an order to follow standing orders.

Review of standing orders revealed emergency measures would be initiated by a licensed nurse immediately when either a routine or stat (right away) CBG (capillary blood glucose) indicates hypoglycemia (low blood glucose). The standing orders further directed for a blood glucose less than 60 the following should be done: If the resident had no renal failure and could take oral food, the resident would be given 15 grams simple carbohydrate (1 tube instant glucose

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(buccal) or 1 AMP (ampule) Glucagon IM (intramuscularly). Then the resident was to be given protein (4 ounces of milk or 1 tablespoon of peanut butter) and carbohydrate (6 saltines or 3 graham crackers). The blood glucose was to then be checked again in 15 minutes and if the response was inadequate the treatment was to be repeated.

On 6/28/24 at 9:54 AM Nurse # 4 documented the following entry. "Resident was alert and responding normally per his baseline at HS (hour of sleep). Resident was hot to the touch and vital signs measured. Resident noted to have temperature of 99.8. Resident received PRN (as needed) Tylenol with scheduled medications and during follow up resident's temperature had fallen to 98.8. At 0600 (6:00 AM) resident's temperature remained within normal ranges."

On 6/28/24 at 1:19 PM Unit Manager # 2 documented the following late entry which indicated when she was called to the room on that date emergency medical staff were with the resident. The entry did not note the time she had been called to the room. The nursing entry read, "Late entry for 06/28/2024. Nurse called to resident's room at this time because staff noted resident not responsive and difficult to arouse. EMT (Emergency Medical Technician) present and resident noted in bed with eyes closed and lethargic. VS (vital signs) 97.6-81-16 98/60 82% oxygenation on room air. Resident given IV glucose prior to transport and now being sent to ER for evaluation. Physician notified at this time."

The day following the resident's 6/28/24 transfer to the hospital Nurse # 4 also entered a nursing entry. Specifically, on 6/29/24 at 9:31 AM Nurse #

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4 documented the following nursing entry. "This writer was made aware that residents blood glucose was measured at 33 by med aides on duty. Upon entering the room, resident was noted to be pale and lethargic. Resident unable to drink orange juice at that time but tolerated sugar mixed in applesauce. Resident blood glucose measured again and read 56. RN Unit Manager on duty arrived to room to assess resident. EMS arrived 9:06 AM and was received report from RN Unit Manager on duty."

Review of EMS (emergency medical system) records revealed the following information. EMS was called on 6/28/24 at 8:56 AM, on the scene at 9:05 AM, and at Resident # 21's side at 9:07 AM. At 9:11 AM the EMS records showed the resident was unresponsive upon their arrival and he had a blood glucose level of 38. Once an IV with dextrose was begun the resident became alert and talking. They were unable to obtain his temperature reading. The resident was transferred to the hospital for evaluation.

Review of Resident # 21's hospital admission history and physical, dated 6/28/24, revealed the physician noted the EMS crew had been summoned to the facility when the resident was found to be profoundly hypoglycemia with a blood glucose reading of 30. The history and physical noted the resident was found to have lactic acidosis related possibly to liver disease or hypoglycemia. (Lactic acidosis is a build- up of lactate acid in the bloodstream which is normally metabolized and can contribute to organ dysfunction). Following hospitalization and treatment, Resident # 21 returned to the facility on 7/5/24.

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F 684	Continued From page 128 On 9/3/24 at 10:55 AM MA (Medication Aide) # 3 was interviewed and reported the following. On 6/28/24 she arrived at work during the morning. MA # 4 had asked for help as she (MA # 3) was coming on duty. MA # 4 informed her that the assigned Nurse Aide had let her (MA # 4) know that Resident # 21 was "gurgling and everything" and she needed help. She (MA # 3) went immediately, and she checked the resident's blood glucose. It was 33. She called the ADON (Assistant Director of Nursing) who told her to call 911. As a medication aide, she thought she could not call 911. Therefore, she ran to get Nurse # 4, who was the night shift nurse and still at work. She told Nurse # 4 that she needed to call 911. At that time Nurse # 4 was still in the medication room. Nurse # 4 did not move to do anything, so she ran to tell another nurse (Nurse # 5). She then went back to the room and started to give the resident some sugar and orange juice under his tongue. She had also asked Nurse # 4 to get some Glucagon, but she never came to help before EMS arrived. When EMS arrived, she (MA # 3) was the only staff member in the room with the resident and he was not responding. Unit Manager # 2 came into the room after EMS arrived. When the Unit Manager arrived, she said that she had come because the ADON had texted her. MA # 3 did not understand why the ADON had texted when they needed help from the nurses right away. Once EMS came to the room, then Nurse # 4 came into the room. The paramedics started asking when Resident # 21's blood glucose was last checked and Nurse # 4 stated she had checked it at 6 AM. Resident # 21's roommate spoke up at that point and said that was not true, and he had been trying to tell someone that there was something wrong with his roommate.	F 684		

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MA # 4 was interviewed on 9/5/24 at 12:06 PM and reported the following. On 6/28/24 during the breakfast time period Resident # 21's assigned NA (Nurse Aide) had let her know that the resident was not acting right and would not talk to the NA. At the beginning of the shift, she had not been told who the nurse was covering her to conduct assessments and things she could not complete as a MA. She went into Resident # 21's room and checked his blood glucose. It was low. She did not recall the exact number. MA # 3 was there and tried to help her. They saw that Nurse # 4 was still there from night shift. They asked Nurse # 4 if there was some glucose that could be given to Resident # 21 and there was none. Nurse # 4 did not come right away to help them, and she did not recall if it was before EMS or after EMS got there that she did come. When she did come, Nurse # 4 did not lay hands on the resident or assess him. She stood and watched as she and MA # 3 were trying to give him some sugar with applesauce, but he was not able to swallow. She recalled that Unit Manager # 2 did come to the room at some point, but she thought it was after EMS arrived. She was at the door when EMS arrived to let them in and the only person in the room with the resident was MA # 3 that she recalled when the EMS team arrived.

Interview with the ADON on 9/5/24 at 1:18 PM revealed she had been the acting DON at the time. She had been aware the resident's blood glucose was low, but she thought the staff had worked together as a team. She did not recall getting a phone call from MA # 3 or that she told MA #3 to call 911. There was supposed to be glucagon on the crash carts for emergencies and in the back up medication supply from the

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pharmacy. She thought that Nurse # 4 helped MA # 4 try to give Resident # 21 a paste of sugar and applesauce (a mixture of sugar in applesauce) while Unit Manager # 2 went to find glucagon. She did know that there had been a problem with them not finding the glucagon, but she thought it was because they had not had an emergency in a while and just had not found it. The glucagon had been present in the facility. She was not aware that the roommate alleged he had tried to tell someone earlier that the resident was not right or that both MA # 3 and MA # 4 were reporting that Nurse # 4 did not come right away. She had not talked to MA # 4 about the situation and did not know she had been involved. The ADON also reported that the resident's roommate could seem as if he was alert, but he was confused at times. (A review of Resident #21's roommate's Minimum Data Set assessments, dated 5/25/24 and 8/25/24, revealed Resident # 21's roommate was cognitively impaired.)

Nurse # 4 was interviewed on 9/6/24 at 7:31 AM and reported the following information. She had already counted off narcotics on 6/28/24 with MA # 4 and finished her night shift. She was still in the medication room documenting. MA # 4 came to get her and let her know that Resident # 21 was clammy. She went with MA # 4 to check Resident # 21's blood glucose. It was low. She did not recall the value. She described to MA # 4 what glucagon looked like on the cart and asked her to get it for her. MA # 4 could not find glucagon on the medication cart. At some point Unit Manager # 2 came also and they were both in and out of the room. They did not leave the resident alone with the medication aides. She went to the emergency medication supply which

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F 684	Continued From page 131 was located on the opposite side of the building at Station # 1. (Resident # 21 resided on Station # 2). When she returned with the glucagon, which she found in the emergency supply, she then found that the first responders and paramedics were in the room and giving other interventions for the low blood glucose. Therefore, she did not give the glucagon she had obtained. Nurse # 4 further reported Resident # 21 had slept during the night before the incident of low blood glucose. She had checked his blood glucose at the due time of 6:00 AM and it was above 100. When she had been called by MA # 4 to come help, she had been finishing her documentation and may have forgotten to chart it. She did not recall Resident # 21's roommate speaking up to say that he had been trying to tell someone that there had been something wrong with the resident before that time. Unit Manager # 2 was interviewed on 9/4/24 at 8:39 PM and reported the following. She had arrived to Resident # 21's room on 6/28/24 because she got a text from the ADON that they needed assistance. The ADON was not in the facility at the time she texted for her (the Unit Manager) to go to the room. The resident was barely responding but was breathing when she arrived. He could not talk and could not open his eyes. He was diaphoretic (sweating heavily). There was no glucagon in the entire facility to give to the resident according to Unit Manager # 2. She thought MA # 3 had been confused about her role as what she could do as a medication aide. There had been directions at the nursing desk that the MAs were to call the ADON. That is why she thought MA # 3 called the ADON rather than activating some sort of emergency system in the facility. Nurse # 4 arrived in the room after the	F 684		

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F 684	Continued From page 132 paramedics got to the room. The EMS crew started asking questions about what Resident # 21's blood glucose had been previously and how he had been. Resident # 21's roommate spoke up and said he had tried to tell someone that the resident was not acting like himself during the night. She Unit Manager # 2) arrived a couple minutes before the fire department and paramedic team. The resident did have vital signs, but she thought in a case such as what happened that a code should have been called by the staff to get help. Unit Manager # 2 also reported she no longer worked at the facility. Nurse # 5 was interviewed on 9/5/24 at 4:15 PM and reported the following information. She had been in the rehab unit on the morning of 6/28/24 and was talking to Nurse # 4 by phone. Nurse # 4 was in the medication room at the time on Station 2. She heard through the phone MA # 3 come to Nurse # 4 and tell her Resident 21's blood glucose was in the 30s. She knew Nurse # 4 got up from the chair because she could hear over the phone her sliding her chair back and the medication room door opening. Then MA # 3 came down to the rehab unit and asked her (Nurse # 5) to call 911. She (Nurse # 5) called 911. After talking to emergency medical services, she (Nurse # 5) then walked from the rehabilitation hall to the nursing desk at Station # 2. She looked down the hall but did not walk to Resident # 21's room. She saw Unit Manager # 2 and Nurse # 4 standing at the doorway of Resident # 21's room and knew they were there. She did not go to the room at that time, and she did not ever see them actually in the room. An attempt was made on 9/5/24 at 2:41 PM to talk to the Nurse Aide who was assigned to care	F 684		

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for Resident # 21 on the night shift prior to Resident # 21 being transferred to the hospital on 6/28/24. The Nurse Aide could not be reached. An attempt was made on 9/5/24 at 2:43 PM to talk to the Nurse Aide who had been assigned on the day shift to Resident # 21 on 6/28/24. The Nurse Aide could not be reached.

One of the paramedics who responded on 6/28/24 was interviewed on 9/5/24 at 10:52 AM and reported the following information. EMS had been summoned because the resident's blood glucose was 30. When they arrived, there was not a licensed nurse in the room with the resident and it "took a hot minute for one to arrive." There was a Medication Aide with the resident, and she had been trying to get orange juice and sugar to him. The paramedic did not know what other specialized efforts had been made before they arrived. One of the nurses that arrived in the room after they got there identified herself as the "house supervisor" (Unit Manager # 2). She talked like she knew what was going on with the resident, "but her words indicated otherwise" because she commented that she did not know why the staff had not given him his insulin. That concerned him that she did not seem to realize that the problem was with the resident's blood glucose being low and not high. When they arrived, the resident was not at a life threatening state at that point, but his low blood sugar could have led to cardiac arrest. The EMS team went to work starting an IV in and getting his blood sugar to rise. Once they got his blood glucose up, they also found that there was a problem with his temperature reading. They went ahead and transported him to the hospital. He did recall there was some discussion in the room about Resident # 21's roommate speaking up about him

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F 684	Continued From page 134 not being checked but he (the paramedic) had not paid a lot of attention because they were focused on getting Resident # 21's blood glucose up, and he did not know if the roommate was alert and oriented to know what he was talking about. The Corporate Nurse Consultant was interviewed on 9/5/24 at 4:15 PM and reported the following information. It was a standard of medical practice to page for help when a resident was in an emergency situation so that multiple staff members could arrive. The resident did not have to be totally without signs of life for a code to be called. According to the Corporate Nurse Consultant a licensed nurse should have assessed the resident prior to EMS arrival and intervened per orders when the resident was not responding and with a low blood glucose. A pharmacist (Pharmacist # 1) was interviewed on 9/6/24 at 11:28 AM and reported the following. The facility has both the injectable glucagon and also glucagon in a gel form within their emergency medication supply. The pharmacy records showed the glucagon was in the medication emergency supply on the date of 6/28/24 and had not needed to be refilled by the pharmacy. There was no glucagon that had been signed out for Resident # 21 on 6/28/24 or any other resident. The first access to the entire emergency medication supply system was on 6/28/24 at 11:45 AM by the ADON. At that time, she had not removed glucagon. On 9/10/24 at 10:29 AM Pharmacist # 2 was also interviewed and reported she could access records which showed whether the drawer of the	F 684		

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emergency medication supply with glucagon was actually opened in an attempt to remove the glucagon. This was because nurses had to log into the computer system for the emergency medications before they could tell which drawer the medication they needed was located. Once a nurse logged into the system, not all the drawers for all the medications opened. No one had logged into the emergency medication supply to access the drawers and remove any type of medication prior to the ADON logging into the system on 6/28/24.

The facility's medical director was interviewed on 9/9/24 at 4:19 PM and details of how the staff reported they had responded to Resident # 21's hypoglycemic episode on 6/28/24 were discussed with the medical director. The medical director reported no one had shared any problems with him about the incident and he had been unaware of any failures on the facility's part to respond.

On 9/6/24 at 5:44 PM the facility Administrator and Corporate Nurse Consultant were notified of Immediate Jeopardy based on findings related to Resident # 21 and Resident # 22.

On 9/9/24 the facility provided the following immediate jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
1. Resident #21 was admitted to the facility on 03/06/2021 and readmitted on 07/05/2024. Between the original admission and readmission, he was discharged to the hospital on 06/28/2024. The most recent readmission, he was readmitted with diagnoses that included: Major depressive

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F 684	Continued From page 136 disorder, Type 2 diabetes with hyperglycemia, cirrhosis of liver, anxiety disorder, dementia, anemia, old myocardial infarction, atherosclerotic heart disease of native coronary artery without angina pectoris (a condition of chest pain or discomfort that happens when some part of the heart doesn't get enough blood and/or oxygen), spastic diplegic cerebral palsy (a neurological disorder that causes muscles to be overly toned), and metabolic encephalopathy (a brain disorder that occurs when an underlying condition causes a chemical imbalance in the blood that affects the brain). Review of Resident #21's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 04/12/2024 indicated that Resident #21 had a Brief Interview of Mental Status (BIMS) score of six which suggests severe impairment in mental status. Review of progress notes documented on 6/29/2024 (late entry), regarding the event happened on 6/28/2024, documented by Nurse #4 in Resident #21's medical records indicated (in part) Nurse # 4 was made aware that Resident #21 blood glucose was measured at 33 by Medication Aide #3. Nurse #4 added, upon entering the room, resident #21 was noted to be pale and lethargic. Resident #21 was unable to drink orange juice at that time but tolerated sugar mixed in applesauce. Resident #21 blood glucose measured again and read 56. Unit Manager #2 arrived in the room to assess resident #21. Emergency medical services (EMS) arrived at approximately 9:05am, documentation concluded. No evidence that code blue (an announcement that indicates a resident is in critical condition and needs immediate medical attention). Nurse #4 did	F 684		

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not administer Glucagon (synthetic hormone that works with other hormones and bodily functions to control blood glucose level), to Resident #21 per physician standing order.

Phone interview was conducted by the Assistant Director of Nursing on 09/07/2024, Nurse #4 reported the following information: Nurse #4 indicated she documented the event on 6/29/2024 as a late entry for an event that happened on 6/28/24, She also added that, she recalled being notified of Resident #21's low blood glucose at approximate 8:30am on 6/28/2024, (initial reported time). After approximately three minutes of being notified, she entered Resident #21's room, Resident #21 was noted to be pale and lethargic, Nurse #4 added. Nurse #4 rechecked Resident #21's blood glucose approximately ten minutes after the initial report, blood glucose read 56. Nurse #4 added, Unit Manager #2 arrived in the room approximately fifteen minutes after the initial report to assess Resident #21. Nurse #4 added, Nurse # 5 contacted the Emergency medical services (EMS) at around 8:56 AM. EMS arrived at approximately 9:05am. Medication Aide #3 was in the room at the time when EMS arrived. Upon EMS arrival on 6/28/24 Resident #21's blood glucose reading was 38, Resident #21 was still nonresponsive at the time EMS arrived. The hospital records indicated the resident was profoundly hypoglycemic.
Resident #21 was readmitted to the facility on 07/05/2024. Resident #21 was assessed by the Assistant Director of Nursing on 09/06/2024 for any clinical signs of hypoglycemia. No signs of hypoglycemia were noted.

2. Resident #22 was admitted to the facility on

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F 684	Continued From page 138 08/02/2023 and discharged on 07/11/2024. Between the original admission and discharge, she was readmitted on 06/21/2024. The most recent readmission, she was readmitted with diagnoses that included: Type 2 diabetes with diabetic retinopathy without macular edema (a complication of diabetes that can cause vision loss and blindness), schizoaffective disorder, dementia, chronic embolism (long-term condition where one or more blood clots block the pulmonary arteries), and thrombosis of distal lower extremity (a blood clot condition that forms within the deep veins, usually of the leg, but can occur in the arms). Review of Resident #22's Medication Administration Records (MAR), indicates; on 7/10/24 at 1:43pm the medication aide (MA #4) notified Unit Manager #2 that Resident #22 had blood glucose levels registering over 400. Resident #22's MAR indicates that Resident #22 received 10 units of Novolog insulin at 1:43pm. Further review of Resident #22's MAR indicates; on 7/11/2024, at 11:47 am, Resident #22's blood glucose was documented to be 400 and 10 units of fast-acting insulin were administered. Review of the Physical Therapy Assistant documentation on 7/11/24 at 3:38 PM the resident was non-responsive, and the Director of Nursing was notified. No documentation of actions taken. The Director of Nursing who was informed is no longer working at the facility. On 7/11/24 at 4:51pm blood glucose documented by MA #4 to be 400. The MAR indicates Resident #22 received 10 units of Novolog insulin. No indication that anything else was done.	F 684		

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F 684	Continued From page 139 Review of progress notes documented on 7/12/2024 (late entry for 7/11/2024), in Resident #22's medical records indicate (in part); Nurse #4 contacted physician due to Resident #22 blood glucose exceeding 400. An order was received from the physician to administer ten units of Humalog or Novolog and report back after 2 hours. After two hours, resident #22 blood sugar reading still exceeded 400 and physician made aware of results, the note added. Resident #22's family arrived and requested that Resident #22 to be sent to the hospital for evaluation. The physician made aware, and the order received to send resident to hospital, documentation concluded. A phone interview was conducted on 09/07/2024 by the Assistant Director of Nursing. Nurse #4 indicated; she contacted physician around 7:10pm on 7/11/2024 due to Resident #22's blood glucose exceeding 400. Nurse #4 added she received an order to administer ten units of Humalog or Novolog and report back after 2 hours. Nurse #4 indicated that she recalled Administering 10units of Novolog to Resident #22 per physician order. Nurse #4 further added that, at approximately 9:00pm, she rechecked Resident #22's blood glucose, the reading still exceeded 400. She added the physician was made aware of the results at approximately 9:03pm. Per Nurse #4, Resident #22's family arrived at approximately 9:05pm and requested for Resident #22 be sent to the hospital. The physician was made aware of the request at approximately 9:10pm, and the order was received to send the resident to hospital, Nurse # 4 contacted EMS at 9:17pm, interview concluded. EMS arrived on scene at 9:32pm. Resident #22	F 684		

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was still non-responsive when EMS arrived. Per EMS report, Resident #22 was found with an elevated heart rate of 140, respirations in the 40s, and with a continued reading of a blood sugar in excess of 400 at time of transport. Resident #22 was sent to the hospital for further evaluation and treatment, Resident #22 left the facility at approximately 9:53pm. Resident #22 is no longer in the facility. No other actions taken.

The Governing body led by the Vice President of Operation, the facility Administrator, Regional Director of Clinical Services, and Director of Nursing conducted the root cause analysis on 09/06/2024, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences.

For Resident #21, the Root Cause Analysis (RCA) identified the alleged noncompliance resulted from the
failure of the facility employee (Nurse # 4) to follow the professional standard of practice on managing hypoglycemia for Resident #21 who was non-responsive on 6/29/2024. The RCA further identified that facility staff also failed to announce "code blue" indicating medical emergency to solicit assistance from other employees in the facility, failure to follow physician order to administer glucagon (synthetic hormone that works with other hormones and bodily functions to control blood glucose level), and failure for facility staff to understand that any employee can call Emergency Medical Services (EMS) for any emergencies in the facility.

For Resident #22, the Root Cause Analysis (RCA) identified the alleged noncompliance

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resulted from the
failure of the facility employee (Nurse # 4) to follow the professional standard of practice on managing repeated episodes of hyperglycemia for Resident #22 who was non-responsive on 7/11/2024. The RCA further identified that the facility failed to have a system in place medication aides to be informed of the licensed nurse responsible to oversee them while on duty.

The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.

Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention. The clinical assessment focused on resident's vital signs to include, blood pressure reading, pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated.

100% audit of all current resident's blood glucose reading documented from 6/28/2024 to

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F 684	Continued From page 142 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a resident with episodes of hypoglycemia and/or hyperglycemia that was not addressed appropriately in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Effective 09/07/2024, facility employees will ensure residents received necessary care to include assessing, monitoring, addressing a change in condition, identify the seriousness of a change in condition, and recognize the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This systemic modification will be accomplished by implementing the following measures: Effective 09/07/2024, licensed nurses will oversee care and services for each resident in the facility. A Nurse # 4 will be informed at the beginning of the shift, through the daily schedule, of his/her responsibility to oversee certified medication aide(s) if any.	F 684		

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Effective 09/07/24, Director of Nursing, Assistant Director of Nursing, Unit Coordinator (#1 or #2), Weekend Supervisor, and/or Scheduling Coordinator will be responsible to update daily schedule for nursing staff (licensed nurses, medication aides, and certified nursing aides). The daily schedule will inform each nursing staff of their assignment and responsibilities to include responsibility for licensed nurses to oversee medication aides (if any).

The Facility Administrator will educate Director of Nursing, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator. The education focused on the importance of ensuring a daily nursing schedule is completed and indicate the responsibility of each nursing staff to include the responsibilities of the licensed nurse to oversee the medication aides. This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24 will not be allowed to work until educated. The Director of Nursing will complete this education for any newly hired, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator during the orientation process effective 9/8/2024.

Effective 09/07/2024 the assigned licensed nurse will be responsible to provide necessary care to include assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for their assigned residents, and/or those assigned to the

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F 684	Continued From page 144 medication aide under the nurse's supervision. Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident's medical records, and inform a Nurse immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Effective 09/07/2024, facility licensed nurses on duty will administer medication related to hypoglycemia and/or hyperglycemia, including glucagon for low blood sugar, and/or insulin for high blood glucose, based on physician orders and document the administration of such medication in each resident's clinical record. Effective 09/07/2024, facility Medical Director approved the protocol for low and high blood sugar. The protocol includes, (in part), residents who are unresponsive and with low blood glucose (less than 60) will receive glucagon injection, administered by a licensed nurse, blood sugar will be rechecked within ten minutes, if blood sugar remain less than 60, and/or resident remain unconscious facility staff will call 911. This protocol is implemented effective 09/07/2024. Effective 09/07/2024, residents with blood	F 684		

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glucose over 400 will receive 10 units of fast acting insulin, (Humalog or Novolog), blood glucose will be rechecked within 30 minutes, or per physician order, after the administration of insulin, if blood glucose remains over 400, resident's physician will be notified for further evaluation and/or treatment. This protocol is implemented effective 09/07/2024.

Effective 09/07/2024, facility employees, including medication aides on duty, will utilize phone intercom communication method and announce "code blue" for any medical emergency to include but not limited to resident change in condition that require clinical support.

Effective 09/07/2024, facility clinical staff, to include licensed nurses, certified medication aides, certified nursing aides, and any other medical/clinical trained professionals will respond to the "code blue" announcement and go to the specified location for assistance. Licensed nurse will provide assistance including assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Effective 09/07/2024, a licensed nurse will remain with a resident with a change in condition that requires emergency medical attention until the emergency medical services (EMS) team arrived for proper monitoring and assessment of the resident.
100% education of all licensed nurses and Medication aides, to include full time, part time,

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and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2).
The emphasis of this education includes but not limited to:
1. The importance of administering medication to include insulin, glucagon, and other medications per physician order.
2. The importance of ensuring each resident is assigned to a licensed nurse to oversee his/her care including provision for assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, and recognizing the need to initiate emergency medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
3. The importance for each medication aide to be aware of their assigned licensed nurse at the beginning of their shift (through the daily schedule that will indicate the nurse who is responsible to oversee them)
4. The use of "code blue" for all medical emergencies through telephone intercom system
5. The implementation of hypoglycemia protocol for unresponsive residents using glucagon for low blood sugar.
6. The implementation of hyperglycemia protocol includes administration of fast acting insulin and rechecking blood sugar within 30 minutes and notifying physician for any other orders.
7. The importance of calling 911 for medical emergencies that require medical attention at the acute care center. (The education emphasized that any staff member can call 911 when indicated.)

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8. Importance for a licensed nurse to remain with a resident until emergency medical services (EMS) arrived.
9. The importance of documenting blood glucose findings in resident's medical records.
10. For medication aides, the education also covered the importance to report to the charge nurse immediately any blood glucose level less than 60, greater than 200 or based on the physician order.

This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation.

Alleged immediate jeopardy removal date: 09/09/2024.

On 9/12/24 the following was done to validate the facility's immediate jeopardy removal plan: Review of records revealed documentation confirming the completion of audits and inservice training per the facility's removal plan.

A review of staffing schedules revealed that there was a designation on the schedule noting which licensed nurse was assigned to cover for any Medication Aide.

Beginning at 9:45 AM on 9/12/24 multiple staff members were interviewed regarding inservice training the facility had provided. Staff were able to report details of their training and validate they attended. Staff were also interviewed regarding

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F 684	Continued From page 148 whether they had witnessed any resident go without medical care during the past week for failure of assessment and notification of the physician of changes. There were no reports of a lack of medical care reported for any residents. The Medication Aide, who was working on 9/12/24, was aware of which nurse was to help her. The assigned nurse was observed checking on the Medication Aide to ensure the Medication Aide was not in need of any assistance on 9/12/24. Nurses were aware where to find glucagon if needed in time of an emergency. Staff were able to validate how they would obtain help in the event of an emergency situation. Arandom interview was conducted on 9/12/24 at 1:35 PM with an alert and oriented diabetic resident regarding her medical care. The resident reported no problems with her diabetic care and reported the staff were "very careful" to keep a check on her blood glucose. She had no care concerns. The facility's IJ removal date of 9/9/24 was validated on 9/12/24. 3a. Resident # 16 was admitted to the facility on 6/17/24 following a fourteen-day hospitalization. According to a hospital discharge summary dated 6/17/24 the resident was treated for acute ulcerative esophagitis, upper gastrointestinal bleeding, and a urinary tract infection while hospitalized. He was also found to be anemic but at his baseline while in the hospital. Additionally, the resident had diagnoses in part which included a hiatal hernia, urinary retention, congestive heart failure, chronic obstructive pulmonary disease, seizure disorder, and hypertension.	F 684		

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The resident's facility admission Minimum Data Set assessment, dated 6/20/24, coded the resident as moderately cognitively impaired.

Review of physician orders revealed on 7/28/24 an order was given and entered into the electronic medical record system for the following labs to be completed: an Fe panel (an iron panel), a CBC (complete blood count), and a BMP (basic metabolic panel). The lab order noted the labs were to be completed on 7/29/24 due to the diagnosis of esophagitis.

There were no lab results found in the record for 7/29/24.

On 7/29/24 the same orders for the Fe panel, CBC, and basic metabolic panel were entered again into the electronic record. The date to be completed was noted to be 7/30/24.

There were no lab results found in the record for 7/30/24.

On 7/30/24 at 9:22 AM Nurse # 6 documented the following information in Resident # 16's record. The resident was noted to have some tremors and congestion that morning. He was easily aroused. His vital signs were stable and his heartrate was elevated. The physician was notified and ordered labs and a chest x-ray to be completed.

Review of physician orders revealed the resident was again ordered to have a CBC. Additionally, the resident was ordered to have a CMP (comprehensive metabolic panel), BNP (brain natriuretic peptide) test (a test that measures for heart failure), a urine analysis and culture, and a

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F 684	Continued From page 150 chest x-ray. These orders were placed in the electronic medical record system to be completed on 7/31/24. Review of Resident # 16's lab results revealed the first labs completed since labs were ordered on 7/28/24 were the ones completed on 7/31/24. The iron panel, which had been ordered due to the resident's history of esophagitis, was still not completed. The report date for the CBC was noted to be 7/31/24. At that time the resident's white blood count was normal. (An elevated white blood cell count can at times indicate infection). The report date for the CMP, BNP, and Urinalysis were documented as reported on 8/1/24. The urinalysis result reported on 8/1/24 showed a preliminary result of greater than 100,000 colonies of gram negative rods (bacteria). The BNP, which was drawn in relation to the resident's heart failure, was elevated. A review of the urine culture result, reported on 8/3/24, revealed there were two bacterial organisms which grew from the culture. A review of Resident # 16's chest x-ray revealed on 7/31/24 the chest x-ray was completed and showed a pulmonary infiltrate consistent with pneumonia. According to orders, which were dated 8/1/24, Resident # 16 was ordered to have Cefuroime Axetil 250 mg (milligrams) two times a day for a diagnosis of urinary tract infection. Nurse # 6 was interviewed on 9/4/24 at 2:09 PM and reported the following information. She recalled the resident had some congestion but he was not in distress on 7/30/24 when the provider was contacted. She called the provider on 7/30/24 as documented by her, and labs were ordered at that time. She did not recall anything in	F 684		

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nursing report about labs already being ordered for him or why they had not been done. She would have found it helpful if they had been done on 7/29/24 when she noticed that he was having some trouble breathing on 7/30/24. She did not recall any urinary symptoms at the time. On 7/31/24 she called the x-ray company to ensure they were coming. The resident was still not in distress at that time.

Review of nursing notes revealed between 7/30/24 to 8/2/24 there were no more nursing notes documenting the resident's status.

Review of hospital records, dated 8/2/24, revealed Resident # 16 was seen in the hospital ED (Emergency Department) for evaluation. The ED physician noted the following. The resident had reportedly not been feeling well for the last two days and also reportedly appeared more confused than usual. The resident had one episode of vomiting on the day of 8/2/24, and the family reported to the ED physician that the resident had being experiencing a productive cough with mucous. The resident was not in distress. The resident's vital signs in the ED were documented to be blood pressure 139/63; pulse 81, temperature 97.9, and respirations 26 with an oxygen saturation of 93%. The resident's chest x-ray showed pulmonary edema which was likely congestive heart failure with small bilateral pleural effusions (build up of fluid between the tissues that that line the lungs and the chest) developing. The ED physician also noted the resident had an indwelling catheter and had "bacteriuria" for which he was asymptomatic. (Bacteriuria is when there is bacteria in the urine). The resident was prescribed to receive Levofloxacin 750 mg every other day and discharged from the ED back to the

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facility.

On 8/3/24 at 4:31 PM a nursing note included documentation the resident had returned to the facility with a diagnosis of a urinary tract infection.

The first record of the iron panel, which had been ordered on 7/28/24, was completed was on the date of 8/7/24. Review of the lab result revealed a low iron level of 29 (normal 59-159). According to the physician orders the resident was receiving iron 325 mg twice per day since 6/18/24 and this iron supplementation was continued.

Interview with Resident # 16's Responsible Party (RP) on 8/28/24 at 3:29 PM revealed the resident had not been feeling well for a couple days before 8/2/24. He (the RP) had been told by the facility the resident had pneumonia and then the resident went to the hospital and the RP was told he had a urinary tract infection. Prior to the resident going to the hospital lab work had been ordered and it took days to get the lab work completed. There seemed to be very poor communication between the staff about things that needed to be done for the resident's medical care.

The ADON (Assistant Director of Nursing) was interviewed on 8/30/24 at 11:55 AM and reported the following information. The residents RP felt as if the resident was flushed and not well prior to 8/2/24 transfer to the hospital. The resident appeared to be at the baseline on 8/2/24. The RP wanted the resident to be evaluated at the hospital and so they sent the resident for evaluation. She was not aware why lab work had not been done for the resident after being ordered on 7/28/24. Routinely, the order would be placed in a lab book so that the phlebotomist, who came

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to the facility in the early AM hours, would know to draw the labs. Following orders on 7/28/24, labs should have been completed on 7/29/24.

3b. Review of physician orders revealed an order, dated 7/3/24, that the resident was to be weighed daily and the physician notified for a three pound weight gain over a time period of two consecutive nights. On 7/16/24 an order was entered into the electronic record again for daily weights to be done.

A review of Resident # 16's record on 8/29/24 revealed weights were not being done daily as ordered. July 2024 and August 2024 weight results documented in the resident's weight record and on the MAR were as follows:
7/5/24-128.8 pounds
7/6/24-131.2 pounds
7/8/24-127 pounds
7/9/24-128 pounds
7/11/24-128.6 pounds
7/14/24-127.8 pounds
7/15/24-127.4 pounds
7/18/24-127.8 pounds
7/19/24-128.4 pounds
7/23/24-128 pounds
7/27/24-129.8 pounds
7/28/24-129.8 pounds
7/29/24-131.2 pounds
8/2/24-131.4 pounds
8/5/24-135 pounds
8/6/24-136 pounds
8/10/24-131 pounds
8/12/24-131.6 pounds
8/15/24-132.4 pounds
8/16/24-133.1 pounds
8/17/24-133.1 pounds
8/20/24-132.4 pounds

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F 684	Continued From page 154 8/25/24-127.4 pounds 8/26/24-127.2 pounds 8-29-24-127.2 pounds Interview with Resident # 16's responsible party on 8/28/24 at 3:29 PM revealed the RP was concerned that the facility staff were not obtaining the resident's weights as ordered. The RP reported the resident had a diagnosis of heart failure and his cardiologist wanted the weights completed to determine if the resident was gaining weight due to fluid. On 8/31/24 at 9:05 AM it was confirmed with the corporate Nurse Consultant that Resident # 16's weights had not been done daily as ordered. There were some dates that were missing.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		10/14/24

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F 690	Continued From page 155 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff and physicians the facility failed to obtain orders for the care of a resident's indwelling urinary catheter. This was for one (Resident # 16) of three sampled residents with indwelling urinary catheters. The findings included: Resident # 16 was admitted to the facility on 6/17/24. One of the resident's diagnoses included urinary retention. The discharge summary also noted the resident had an indwelling urinary catheter and discharge orders included the instructions that the catheter should be changed monthly. There was a notation in the discharge summary that the next due date for catheter change was on 7/3/24. Review of Resident # 16's admission Minimum Data Set assessment, dated 6/20/24, revealed	F 690	F690 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #16 no longer in the facility, no other actions taken for resident #16 Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of all current residents with indwelling catheters in the facility completed on 10/02/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with an indwelling catheter without an order and/or proper indication for use. no admission orders. No other resident was identified without appropriate orders for the use of indwelling catheter. Findings of	

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the resident had an indwelling urinary catheter.

Review of the resident's care plan, dated 8/9/24, revealed no mention of the urinary catheter.

A review of physician orders for Resident # 16 revealed no orders for the care of the urinary catheter or when it was to be changed.

On 7/30/24 at 9:22 AM Nurse # 6 documented the following information in Resident # 16's record. The resident was noted to have some tremors and congestion that morning. He was easily aroused. His vital signs were stable and his heartrate was elevated. The physician was notified and ordered labs and a chest x-ray to be completed. One of the labs ordered was for a urinalysis and urine culture. Another lab, which was ordered, was for a complete blood count.

Review of Resident # 16's lab results revealed the urinalysis result reported on 8/1/24 showed a preliminary result of greater than 100,000 colonies of gram negative rods (bacteria). A review of the urine culture result, reported on 8/3/24, revealed there were two bacterial organisms which grew from the culture. A review of Resident # 16's chest x-ray revealed on 7/31/24 the chest x-ray was completed and showed a pulmonary infiltrate consistent with pneumonia.

According to orders, which were dated 8/1/24, Resident # 16 was ordered to have Cefuroxime Axetil (an antibiotic) 250 mg (milligrams) two times a day for a diagnosis of urinary tract infection.

Nurse # 6 was interviewed on 9/4/24 at 2:09 PM

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this audit are documented on the indwelling catheter audit tool located in the facility compliance binder.
Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:

Effective 10/07/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe all orders to resident□s medical records to include orders for indwelling catheters and other orders that are necessary for resident care in the facility. Any resident admitted with an indwelling catheter without proper indication, the attending physician will be informed immediately for clarification.

Effective 10/07/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2, will incorporate the process of discussing residents admitted with, or with new orders for indwelling catheters to validate each has a proper indication of the use, and physician order is transcribed correctly in facility□s electronic medical records. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting that takes place Mondays to Fridays.

DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed

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and reported the following information. She recalled the resident had some congestion but he was not in distress on 7/30/24 when the provider was contacted and she did not recall any urinary symptoms.

Review of nursing notes revealed between 7/30/24 to 8/2/24 there were no more nursing notes documenting the resident's status.

Review of hospital records, dated 8/2/24, revealed Resident # 16 was seen in the hospital ED (Emergency Department) for evaluation. The ED physician noted the following. The resident had reportedly not been feeling well for the last two days and also reportedly appeared more confused than usual. The resident had one episode of vomiting on the day of 8/2/24, and the family reported to the ED physician that the resident had being experiencing a productive cough with mucous. The resident was not in distress. The resident's vital signs in the ED were documented to be blood pressure 139/63; pulse 81, temperature 97.9, and respirations 26 with an oxygen saturation of 93%. The resident's chest x-ray showed pulmonary edema which was likely congestive heart failure with small bilateral pleural effusions (build up of fluid between the tissues that that line the lungs and the chest) developing. The ED physician also noted the resident had an indwelling catheter and had "bacteriuria" for which he was asymptomatic. (Bacteriuria is when there is bacteria in the urine). The resident was prescribed to receive Levofloxacin 750 mg every other day and discharged from the ED back to the facility.

On 8/3/24 at 4:31 PM a nursing note included documentation Resident # 16 had returned to the

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employees (PRN). The emphasis of this education will be the importance of ensuring each resident with an indwelling catheter has a physician order in place that include the type of indwelling catheter, size, and indication of the catheter use. The education also emphasized that resident who enters the facility without an indwelling catheter should not be catheterized unless the resident□s clinical condition demonstrates that catheterization was necessary, and ordered by a physician, resident with an indwelling catheter is assessed for removal of the catheter as soon as possible unless the resident□s clinical condition demonstrates that catheterization is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:
Effective 10/07/2024, DON and/or ADON will monitor compliance with indwelling catheter orders by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team validated each resident with n indwelling catheter had a proper indication

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facility with a diagnosis of a urinary tract infection.

Resident # 16's Responsible Party was interviewed on 8/28/24 at 3:29 PM and reported the following. The resident was routinely seen by a urologist and his indwelling urinary catheter was to be changed monthly. The facility had made no efforts to obtain urology consult notes from the times when the RP would take the resident to visit the urologist and they would not change the catheter as the urologist wanted. The urinary catheter was not changed from 6/17/24 through 8/2/24. When the resident went to the hospital, the hospital staff changed the catheter and said he had a urinary tract infection. The facility staff had told the RP that the resident's chest x-ray before the resident went to the hospital had shown pneumonia.

The ADON (Assistant Director of Nursing) was interviewed on 8/29/24 at 12:15 PM and the record was reviewed with her. The ADON validated there were no orders for Resident # 16's urinary catheter. She further reported orders from the physician should have been obtained when the resident was admitted and should have included how often the catheter was to be changed. Another interview with the ADON on 9/5/24 at 1:19 PM revealed although there had been no orders, she felt as if the nursing staff were providing catheter care although the urinary catheter had not been changed by them.

Resident # 16's physician was interviewed on 9/9/24 at 4:19 PM. According to the physician the resident's abnormal urine labs could have possibly been related to colonization (bacteria in the urine without causing problems or sickness) rather than an active infection, and the antibiotic

F 690

and a physician order in the facility electronic health records. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Foley orders review monitoring tool located in the facility compliance binder.
Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.
Compliance date 10/14/2024.

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F 690	Continued From page 159 would have still been warranted given the resident had a positive chest x-ray for pneumonia on 7/31/24. The physician also reported not changing the resident's urinary catheter in a month's time had not put him at greater risk for infection. He often refers to urologist, and some urologist want the urinary catheter changed on different schedules.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, Emergency Medical Services (EMS) record, staff and family interviews the facility failed to provide respiratory care services for one (Resident #4) of three residents reviewed for respiratory care. Findings included: There was no documentation in the electronic medical record of Resident #4 other than the hospital discharge summary dated as uploaded by the facility on 7/10/2024. The hospital discharge summary, for the 7/3/2024 to 7/10/2024 hospital stay, revealed Resident #4 had the discharge diagnoses of generalized muscle weakness, chronic lymphocytic leukemia, age related physical debility, primary hypertension, Stage 3 chronic kidney disease,	F 695	F695 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #4 no longer in the facility, no other actions taken for resident #4 Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of all current residents who are on oxygen supplement therapy completed on 10/03/2024 by the Director of Nursing, Assistant Director of Nursing, unit coordinator (#1 or #2) and/or medical records coordinator to identify any other resident with oxygen therapy without an	10/14/24

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F 695	Continued From page 160 Type 2 diabetes mellitus, and a history of transient ischemic attack (stroke). The hospital discharge summary listed an expected medication list at discharge but did not include any orders for oxygen. There was no documentation of any orders or any admission documentation in the electronic medical record to indicate initial orders were obtained for Resident #4 from a facility physician. An interview was conducted with the family member of Resident #4 on 8/28/2024 at 12:53 PM. The family member provided the following information about the stay of Resident #4 in the facility. Resident #4 arrived from the hospital at the facility on 7/10/2024 at 5:30 PM. Resident #4 was paralyzed and was unable to move on his own. Resident #4 was receiving oxygen from an oxygen concentrator that sounded like a jet engine and was very loud. The family of Resident #4 asked a nurse aide to help them find another oxygen concentrator because the one in the room was too loud and there was a concern it might be broken. The nurse aide told the family they would let the nurse for the hall know of the concern for the oxygen concentrator. The nurse for the hall never came down to the room so the family member went to the desk to seek her assistance. The nurse at the desk told the family member of Resident #4, she would be down to the room to help them in a minute and that she was very busy at that moment. Another nursing staff member came to the room and stated they would find another oxygen concentrator. When another oxygen concentrator was brought, it did not work either because it needed to have water per nursing staff member. The family stated at that point Resident #4 had been in the facility for	F 695	order. No other resident identified. Findings of this audit are documented on the oxygen therapy audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 10/07/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe all orders to resident□s medical records to include orders for Oxygen therapy and other orders that are necessary for resident care in the facility. Any resident admitted with an Oxygen therapy without an order, the attending physician will be informed immediately for clarification. Effective 10/07/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2, will incorporate the process of discussing residents admitted with, or with new oxygen therapy and ensure they have a physician order for the use of oxygen supplement in facility□s electronic medical records. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting that takes place Mondays to Fridays. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of	

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F 695 Continued From page 161

several hours and nobody had come to assess him or make sure he was receiving adequate oxygen. The family of Resident #4 called for emergency medical services to take Resident #4 back to the hospital at approximately 7:00 PM.

An interview was conducted with Nurse #2 who was assigned to care for Resident #4 on 7/10/2024 upon admission. Nurse #2 stated she remembered on 7/10/2024 the facility was receiving a lot of new admissions. Nurse #2 revealed she was not able do any of the admission paperwork on 7/10/2024 because she was a licensed practical nurse (LPN) and not a registered nurse (RN). Nurse #2 explained that she did not do any assessments or any of the initial documentation for Resident #4, and that an RN came over to the hallway to assist her with admissions. Nurse #2 stated she did not go down to the room to see Resident #2 as she was very busy, but did recall the family member requesting her assistance with the oxygen concentrator because it was too loud.

Nurse Aide (NA #5) was interviewed on 8/29/2024 at 4:14 PM. NA #5 revealed she was an agency nurse aide who was assigned to care for Resident #4. NA #5 stated Resident #4 was already in bed when she arrived for work, so she did not know when the resident arrived at the facility. NA #5 stated the oxygen concentrator in the room for Resident #4 was making a loud rumbling noise and was aggravating the resident. NA #5 stated she was trying to be helpful, so she went looking for another oxygen concentrator and located one in another resident's room. NA #5 stated she did not know anything about oxygen concentrators, so she went to ask the nurse at the desk (Nurse #2) for assistance. Nurse #2 said

F 695

ensuring each resident who receives oxygen supplement has a physician order in place that include the amount (liters), and frequency (continuous or as needed). This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 10/07/2024, DON and/or ADON will monitor compliance with oxygen therapy orders by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team validated each resident had the admission orders in resident□s electronic medical records, including oxygen supplement orders if any. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a orders review monitoring tool located in the facility compliance binder.
Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring

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F 695	Continued From page 162 she was too busy to come to the room, so NA #5 revealed she asked a Medication Aide on another hall for assistance. An interview was conducted with Med Aide # on 9/3/2024 at 12:13 PM. Med Aide #3 revealed the following information. Med Aide #3 was a medication aide on an adjoining hall to the hall for which Resident #4 resided. Med Aide #3 went to the room of Resident #4 because NA #5 requested assistance with an oxygen concentrator because the oxygen concentrator was too loud. Med Aide #3 stated the orders from the hospital were laying in a folder in the room of Resident #4 she assumed those were the orders called into the facility from the hospital. Med Aide #3 stated she tried to hook up the humidifier bottle on another oxygen concentrator, but Resident #4 was struggling a little to breathe. The family opted to call EMS before she could get an alternate oxygen concentrator to work. Documentation in an EMS patient care record dated 7/10/2024 revealed EMS staff arrived at Resident #4 at 7:40 PM. The EMS record provided the following information. Resident #4 was laying down upon arrival, speaking coherently, in no pain, or distress. The family advised EMS they were not happy with the care at the facility and wanted him transported back to the hospital. Resident #4 was on 2.5 liters per minute (LPM) of oxygen via nasal cannula started by the facility. Resident #4 denied any shortness of breath and was started on 3 LPM of oxygen. Resident #4's oxygen saturation level was assessed as being 89 % so the oxygen was increased to 4 LPM, after which his oxygen saturation level improved to 94 %.	F 695	or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.	

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F 695	Continued From page 163 An interview was conducted with Unit Manager #2 on 8/30/2024 at 3:20 PM. Unit Manager #2 revealed it was very difficult admitting residents on 7/10/2024 because the facility was trying to transition from one medical record database to another. Unit Manager #2 stated she was only informed of Resident #4 and an issue with an oxygen concentrator as the family was ready to leave with the resident. Unit Manager #2 indicated the oxygen concentrator for Resident #2 was working but it was louder than normal. Unit Manager #2 stated Resident #2 was not in distress when he left the building and was calm as EMS took him away. An interview was conducted with the facility nurse consultant on 8/31/2024 at 7:58 AM. The facility nurse consultant acknowledged the facility had problems with the admission process in the beginning of July 2024 and he confirmed he was unable to locate any additional documentation or information regarding the admission of Resident #4.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 725		10/14/24

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F 725	Continued From page 164 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, and family the facility failed to ensure a system was in place to manage call outs in nursing so incontinent care and showers could be provided. This was for one of four residents reviewed for sufficient staff to meet residents' individual needs (Resident #2). The findings included: Record review revealed Resident # 2 was admitted to the facility on 10/27/23. The resident's diagnoses included in part a history of congestive heart failure, a history of spinal stenosis and stroke. The resident also had a diagnosis of peripheral neurofibromatosis (a genetic condition that causes skin tumors). Resident # 2's significant change Minium Data Set assessment, dated 8/22/24, coded the resident as moderately cognitively impaired. The resident was also assessed to be totally dependent on staff for bed mobility, hygiene	F 725	F725 Sufficient Nursing Staff What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Resident #2 was immediately offered a shower and checked to ensure there were no negative signs or symptoms related to waiting to be changed, of which, there were none. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. 100% audit will be done on the next 2 weeks of staffing schedules to ensure that there is an appropriate amount of staffing, this audit will be done by the administrator on 10/2/2024. What measures will be put into place or	

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F 725

Continued From page 165

needs, toileting needs, and bathing needs. He was assessed to be frequently incontinent of bowel and bladder.

Review of Resident # 2's care plan revealed it had been updated on 7/18/24 to include that the resident required assistance with his activities of daily living due to congestive heart failure and chronic medical conditions. The care plan also noted the resident was incontinent of bladder and bowel, and staff were directed on the care plan to assist the resident with care.

Resident # 2 was interviewed on 8/28/24 at 3:50 PM and reported the following information. He often had to wait to be changed when he was incontinent. There had been a recent incident during which he waited for hours and had soiled himself with both urine and stool.

Resident # 2's responsible party was interviewed 8/28/24 at 1:43 PM and reported the following information. Resident # 2 often had to wait to be changed. He would call her about the situation, and she would take notes. There had been an incident on 8/18/24 when he had called her around 8:30 AM letting her know he was waiting to be changed. He had soiled himself. He called her that same day at 4:00 PM letting her know that they had just changed him at 3:00 PM. They had not had enough staff to change him. The RP also reported Resident # 2 had special skin needs due to his neurofibromatosis. Areas on his back would drain. He was supposed to get showers on the weekend but those had not been done due to not enough of staff members to do the showers.

A review of assignment sheets and time cards

F 725

what systemic changes will you make to ensure that the deficient practice does not recur?
Before clinical, the DON and the Administrator will review the staffing schedule for the following day with the scheduler to ensure that adequate staffing are scheduled to work the next day. If there is not adequate staffing, the scheduler will work to fill the openings with PRN staff and agency. If there are call in during the weekend, then PRN staff and agency staff will be utilized. If neither of these options are available, a bonus will be offered to staff to pick up and if still there is a vacancy, then one of the nurse managers will cover the shift.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?
The assistant administrator will audit the daily schedule to ensure that there are no unfilled openings on the schedule. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation.

Compliance date: 10/14/2024

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F 725	Continued From page 166	F 725		

revealed on 8/18/24 there were six Nurse Aides who had recorded working hours for the day shift of 8/18/24 for the entire facility.

On 9/4/24 at 3:48 PM the facility corporate Nurse Consultant reported that the census on the 300/400 halls was 66 on the date of 8/18/24.

Nurse Aide # 8 was interviewed on 9/3/24 at 7:20 PM and reported the following information. On 8/18/24 there were only two Nurse Aides for the day shift for the 300 hall and 400 hall. She had been one of those Nurse Aides and had been assigned to Resident # 2. What he reported regarding not receiving incontinent care was true. The Nurse Aide # 8 reported that there were so many residents for whom they had to care that it was just not possible to get to Resident # 2 sooner than she did. In addition to making rounds for hygiene and incontinent care, the two Nurse Aides had to pass out trays and feed residents for the breakfast and lunch meal. The Nurse Aide asked the surveyor to "do the math" and calculate the amount of minutes she had been able to afford each of her residents in a eight hour shift. She was not able to give showers. Showers for one resident could take a great deal of time and there was just not enough time to do so.

The scheduler was interviewed on 8/30/24 at 3:55 PM and reported the following information about weekend staffing. Most of the time she was able to work from home calling for staff and sometimes she had to come in if she could not find anyone. She was aware there were call outs from agency workers on the weekend due to various reasons such as sick children or life in general. She (the scheduler) kept in contact with the weekend supervisor regarding weekend

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F 725	Continued From page 167 staffing issues and they worked together. Interview with the weekend Nursing Supervisor on 8/29/24 at 8:05 PM revealed the following information. She specifically recalled the weekend of 8/17/24 and 8/18/24. There were multiple agency Nurse Aides who had been scheduled but did not show up or call to give notice. That left them with fewer Nurse Aides than scheduled, and there had been no replacements that came to assist. The Nursing Supervisor was interviewed about the timeliness of rounds to change residents and responded that the staff did make rounds, but the Nurse Aides were only able to make about two rounds per shift due to the number of residents they had. The Nursing Supervisor was interviewed regarding whether there had been enough time to give showers to residents on that weekend and she reported there was not enough time to do so. The weekend Nursing Supervisor reported overall the weekend staffing over the past month had not been good and attributed it to agency Nurse Aides not coming to work or calling. It had made it very difficult to provide care. The weekend Nursing Supervisor reported "once in a while" the scheduler would come in and help. Interview with the Corporate Nurse Consultant on 8/31/24 at 12:00 PM revealed the facility was currently working on staffing and trying to hire quality employees after ending employment with multiple employees in recent weeks. While they were working to hire their regular staff, they were utilizing an agency hub which worked to provide staff members from different agencies to the facility.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		10/14/24

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CFR(s): 483.45(a)(b)(1)-(3)

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). 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 observation, record review, resident interview, staff and pharmacist interview the facility failed to 1) ensure an accurate accounting system for controlled substances for three

F755
Corrective actions accomplished for those residents found to be affected by the deficient practice:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 169 (Residents # 26, #27, and #28) of three sampled residents whose controlled substance records were reviewed and during a time in which the facility was accountable for overseeing a nurse working under a restricted nursing license related to narcotic handling and 2) ensure medications were available and administered for one (Resident # 10) of seven sampled residents reviewed for pharmacy services. The findings included: 1a. Resident # 27 was admitted to the facility on 8/20/24. One of the resident's diagnoses included osteomyelitis. Review of orders revealed an order dated 9/4/24 for Oxycodone 5 mg (milligrams) every six hours as needed (PRN) for pain. Resident # 27's controlled drug receipt record was reviewed on 9/12/24 for the dates of 9/5/24 through 9/12/24. (The controlled drug receipt record is a form which details how many doses of a controlled substance were sent to the facility from the pharmacy. Nurses are required to sign, date, and time the removal of each dose from a resident's supply of a controlled substance which is maintained in double locked storage prior to administering the controlled substance to a resident). Resident # 27's controlled drug receipt record for Oxycodone revealed for multiple times the Oxycodone had been signed out on the controlled drug receipt record without any documentation of the administration on the September 2024 MAR (medication administration record). The above was confirmed with the Corporate Nurse Consultant on 9/12/24 at 2:45 PM.	F 755	1. Resident #10 no longer in the facility, no other actions taken for resident #10 2. Resident #26 no longer in the facility, no other actions taken for resident #26 3. Resident #27 no longer in the facility, no other actions taken for resident #27 4. Resident #28 no longer in the facility, no other actions taken for resident #28 Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of current residents with orders for Clonazepam and other antianxiety medication completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 10/07/2024 to identify any other resident who did not receive antianxiety medication per physician orders in the last two weeks. Findings of this audit are documented on an antianxiety medication audit tool located in the facility compliance binder. 100% audit of the controlled drug receipt/record/disposition form for current residents with orders for controlled medication completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 10/07/2024 to identify if medication were removed from the card per physician order. This audit compared the documentation of removed medication as documented on the controlled drug receipt/record/disposition form to the documentation of medication administration for last 14 days. Findings of this audit are documented on Narcotic count validation tool located in the facility	

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F 755	Continued From page 170 According to the Corporate Nurse Consultant, it was felt that the nurses were failing to document the actual administration of the Oxycodone every time it was needed and administered. Interview with Resident # 27 on 9/12/24 at 1:40 PM revealed she did experience pain, and the nurses had been providing her with her PRN (as needed) Oxycodone when she requested it. 1b. Resident # 26 was admitted to the facility on 8/20/24 after having a new knee prosthesis (knee joint replacement). Review of physician orders revealed orders, dated 8/26/24, for Oxycodone 2.5 mg every four hours as needed for pain. On 9/3/24 the resident had an order for Oxycodone 2.5 mg every four hours as needed for mild to moderate pain and 5 mg for severe pain. Resident # 26's controlled drug receipt record for Oxycodone for 9/1/24 to 9/12/24 revealed multiple times the Oxycodone had been signed out on the controlled drug receipt record without any documentation of the administration on the MAR (medication administration record). The above was confirmed with the corporate Nurse Consultant on 9/12/24 at 2:45 PM. According to the Corporate Nurse Consultant, it was felt that the nurses were failing to document the actual administration of the Oxycodone every time it was needed and removed from drug storage. Interview with Resident # 26 on 9/12/24 at 1:35 PM revealed she did experience pain, and the nurses had been providing her with her PRN (as	F 755	compliance binder. 100% audit of records of controlled drug substances delivered to the facility in the last 14 days completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 10/07/2024 to identify validate the record of the controlled substance delivery, removal per documentation on receipt/record/disposition form, and return to pharmacy. Findings of this audit are documented on Narcotic records validation tool located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 10/07/2024, facility employees will administer medication based on physician orders to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record. On 09/16/2024, Regional Director of Clinical services revised the change of shift narcotic count sheet to include the provision for two nurses to validate the change in count every shift. The revised form is used effective 09/17/2024. Effective 10/07/2024, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit coordinator #1 or #2 revised the shift change process to include the revised change of shift narcotic count sheet that includes provision for validating the accuracy of controlled drug including	

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F 755	Continued From page 171 needed) Oxycodone when she requested it. 1c.. Resident # 28 resided at the facility from 2/27/20 until her death on 8/19/24 while under hospice care at the facility. Review of Resident #28's orders revealed an order, dated 8/6/24, for morphine sulfate 100 milligrams/5 milliliters (ml) give .25 ml (5 mg) four times per day. Additionally, the resident could have .25 ml every two hours as needed for break though pain. A review of Resident #28's August 2024 MAR (medication administration record) revealed Wound Care Nurse # 2 (who was working as a staff nurse on 8/18/24) signed as administering the Morphine on 8/18/24 at 9:00 AM; 12:00 PM; and 5:00 PM per the MAR's scheduled times. Review of hospice notes, dated 8/18/24, revealed hospice received a call at 5:13 PM from Resident # 28's RP (responsible party) that the resident's breathing was heavier and faster and the RP was concerned whether the resident was receiving her Morphine due to the resident sleeping. Continued review of hospice notes revealed documentation that the hospice nurse arrived on 8/18/24 at 6:55 PM and documented the following information. The RP reported to the hospice nurse the resident had increased secretions all day and she (the RP) was also concerned the resident was not receiving her Morphine as ordered. The hospice nurse noted the resident was not responding, had reportedly had no intake for three days, and had both an elevated heart rate and respirations. She (the hospice nurse) talked to Wound Care Nurse # 2 and Nurse # 4	F 755	oxycodone and clonazepam. This process will ensure medication is removed from the card based on the physician orders and, if otherwise, proper documentation will be included on the disposition of any medication removed/not removed from the card. Finding of this systemic change is documented on the narcotic count sheets located in the narcotic count binders on each medication cart. Effective 10/07/2024, the facility□s nursing administrative team, which includes the DON, ADON, Unit coordinators (#1, #2), and/or wound nurse, incorporated the process for reviewing medication not administered report from the facility electronic health record for the last 24 hours, or from the last clinical meeting to ensure residents receive medication based on physician orders. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the clinical meeting taking place Mondays to Fridays. Any identified issues will be addressed promptly by the DON, ADON and/or Unit Coordinators #1 or #2. 100% education of all Licensed nurses and Medication aides to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of administering medication to include	

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and was advised by Wound Care Nurse # 2 that the resident had received the Morphine at 5:00 PM. An additional dose of Morphine was administered while the hospice nurse was at the facility per the PRN (as needed) order.

The hospice nurse was interviewed on 9/11/24 at 5:00 PM and reported the following information. When she arrived on 8/18/24 the resident did appear uncomfortable. Her heart rate was "quite elevated" and her respirations were also elevated. She spoke to Wound Care Nurse # 2 who showed her on the electronic MAR that the morphine had been given at 5:00 PM. She (the hospice nurse) had also spoken to the RP and the RP did not recall any nurse coming into the room to administer morphine that afternoon. That is why the RP had called hospice. The RP was not sure if she could have stepped out to the restroom. While the hospice nurse was at the facility and after talking to Wound Care Nurse # 2 and Nurse # 4, a PRN dose of Morphine was given to Resident # 28. The hospice nurse reported the PRN Morphine dose was beneficial in making the resident more comfortable.

Resident # 28's RP was interviewed on 9/11/24 at 5:45 PM and reported the following information. She had been at the facility from 12:00 PM all afternoon. Resident # 28 was not able to report pain but appeared uncomfortable. The resident's breathing was labored. The resident's chest was heaving to the extent her shoulders were moving with her breathing. She did not recall any nurse coming into the room to administer Morphine to the resident and therefore she called the hospice nurse around 5:00 PM. She did not recall going to the bathroom that afternoon or leaving the bedside of Resident # 28.

F 755

anti-anxiety medication, and other medications per physician order. Staff education also focused on the revised process for shift changes that include validating the count and ensuring medication was removed from cards per physician orders, and process to reorder medication from pharmacy in a timely manner. This education will be completed by 10/14/24. Any Licensed nurse and/or medication aide not educated by 10/14/24 will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new Licensed nurses and medication aides effective 10/14/2024
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for pain medication, and other medication to ensure Licensed nurses and medication aides are administering such medication per physician orders. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication review monitoring tool

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F 755	Continued From page 173 Wound Care Nurse # 2 was interviewed on 9/12/24 at 1:08 PM and reported the following information. She did not recall the RP alerting her to any concerns about Resident # 28, and she had administered the Morphine as ordered. The resident's breathing had not been labored that she had recalled prior to the hospice nurse visiting. The Corporate Nurse Consultant was interviewed on 9/11/24 at 11:52 AM and reported the following. Resident # 28's remaining morphine had been sent back to the pharmacy for destruction on 8/21/24 following the resident's death on 8/19/24. The facility had searched their records and were unable to find Resident # 28's controlled drug receipt records for the Morphine to show when the Morphine had been signed out and by whom and on which date. The facility had undergone a change in ownership in recent months and recently items/paperwork had been packed and removed from the facility. Although Resident # 28's August 2024 Morphine accounting records were part of the facility's responsibility while under the new corporate owner, it was thought that they were inadvertently packed and sent away. They had no way of showing when the Morphine had been removed from storage for administering on 8/18/24. A review of Wound Care Nurse # 2's personnel records revealed she was currently working under a restricted license per directions from the North Carolina Board of Nursing for prior incidents where she was found to have removed multiple controlled substances without consistently documenting the administration.	F 755	located in the facility compliance binder. Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the controlled medication monitoring process. This monitoring process will be accomplished by reviewing the controlled drug receipt/record/disposition form for all residents with orders for narcotic medication orders to ensure medication was removed from the card per physician order. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Narcotic count review monitoring tool located in the facility compliance binder. Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete medication availability monitoring process. This monitoring process will be accomplished by reviewing five randomly selected residents□ orders and validating the availability of medication in the medication cart. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring	

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Interview with a facility pharmacist on 9/12/24 at 12:17 PM revealed facilities were required by law to keep all controlled drug receipt records for three years and that the pharmacy recommended they keep them for five. The pharmacist validated there should be some sort of accounting for Resident # 28's morphine sulfate which the facility did not have.

On 9/12/24 at 1:15 PM Nurse # 2 (a randomly interviewed nurse) was interviewed about the accounting of controlled substances on her medication cart located on the rehab unit and observations were made. A review of the controlled substances in Nurse # 2's double locked storage revealed there were 16 bubble cards with controlled substances and there were 16 controlled drug receipt records that corresponding to each bubble card (indicating each card had an accounting sheet). The number of medications on each controlled substance bubble card was observed to be correct according to the individual controlled drug receipt records. Then the "controlled substance count sheet" was reviewed with Nurse # 2. (This sheet included signatures for oncoming and off going nurses to sign that the accounting of controlled substances was correct at each shift change.) On the sheet, there was a notation about how many individual sheets/individual controlled substance bubble cards should be in the rehab medication's locked drawer at each shift change. On 9/12/24 at 1:15 PM this count sheet showed there were 16 sheets on hand and therefore 16 controlled substance bubble cards. According to the sheet, nurses were to make a notation if they removed a sheet/controlled substance or added a sheet/controlled substance to the over -all count. They were also to initial

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process will be documented on a Medication availability monitoring tool located in the facility compliance binder. Effective 10/14/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication administration monitoring process. This monitoring process will be accomplished by reviewing medication administration audit report ensure no resident is listed with missing medication administration. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication administration monitoring tool located in the facility compliance binder. Effective 10/14/2024, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived.

Compliance Date: 10/14/2024

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F 755	Continued From page 175 when this was done and note on which date. In reviewing with Nurse # 2, she validated the count sheet showing the number was 16 total was not clear due to unclear documentation about controlled substances being removed and or added on previous days. The count sheet being viewed by Nurse # 2 and the surveyor started on the date of 9/9/24. On that date there were 21 individual sheets at 7 AM. The count sheet noted between the dates of 9/9/24 at 7:00 AM and 9/12/24 there had been multiple bubble cards with controlled substances and the accompanying controlled drug receipt records for each bubble card added or deducted to the total count sheet without it always being clear when they were added/deducted, by whom and at what time they were added/deducted. Also, it was noted that for one resident Lyrica had been removed on 9/10/24 and appeared to be added back on 9/11/24. Nurse # 2 was unclear when looking at all the removals and additions if there should be 16 controlled substance bubble cards in the rehab cart's locked storage or whether there should be more or less. The new interim DON (Director of Nursing) also reviewed the count sheet on 9/12/24 at 2:00 PM and also reported it was not clear. She reported that she thought the facility was supposed to be utilizing a different count sheet which was part of the new corporation's records, and which made it easier to note the removal and addition of new controlled substances for better clarify. The Corporate Nurse Consultant and current Administrator were interviewed on 9/12/24 at 2:45 PM and also reported the count sheet was not clear. According to the Corporate Nurse Consultant he felt some of the problem was from the nurses not documenting the correct	F 755		

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F 755	Continued From page 176 subtraction and addition of sheets/controlled substances to the count sheet. He further reported the following. Two nurses should be signing and dating when new controlled substances were added or removed to the count sheet. This had not been happening. When a resident left, then an accounting should go to the Director of Nursing and any left- over controlled medications should be kept under locked storage by the DON prior to being picked up by the pharmacy for destruction. The accounting system should be one which allowed the facility to track the receipt, the accounting of stored controlled substances and the administration of doses from the time a controlled substance was received from the pharmacy, administered, and any extra doses returned to the pharmacy or resident upon discharge. According to the Corporate Nurse Consultant he had identified the problem and was working on a system to ensure the accuracy of the accounting. There were no reports or suspicion that any controlled substances were being diverted. According to the Corporate Nurse Consultant the Wound Care Nurse would not have been allowed to work if the Board of Nursing had felt there was definitive evidence of any diversion on her part, and that was not suspected by the facility. 2a. Resident # 10 was admitted to the facility on 7/22/24 with diagnoses that included osteoarthritis and anxiety disorder. Resident was admitted to the hospital on 8/17/24 and readmitted to the facility on 8/27/24. Resident #10's admission Minimum Data Set (MDS) assessment dated 7/24/24 revealed he was cognitively intact.	F 755		

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F 755	Continued From page 177 Review of orders revealed an order dated 7/25/24 for Clonazepam .5 mg (milligrams) every twelve hours as needed (PRN) for anxiety and an order Oxycodone 5 mg (milligrams) every six hours as needed (PRN) for pain. An interview was conducted with Resident #10 on 8/28/24 at 9:55 AM who stated he had missed some of his doses of his medication since his return from the hospital. He stated it was his pain medication (Oxycodone) and his anxiety medication (Clonazepam). During an interview with Resident #10 on 8/30/24 at 10:37 AM he stated he had received his pain medication as requested but had not received his anxiety medication. He reported he had been informed it had not come in from the pharmacy. During an interview with Nurse #1 on 8/30/24 at 10:41 AM she stated she was unable to locate any Clonazepam on the medication cart for Resident #10. She stated she was unable to determine if his Clonazepam had been administered since his return from the hospital on 8/27/24. A second interview was conducted with Nurse #1 on 8/30/24 at 1:10 PM and she stated Resident #10's Clonazepam should be delivered the evening of 8/30/24. An interview was conducted with the Pharmacy Manager at the facility's contracted pharmacy on 8/30/23 at 1:16 PM. The Pharmacy Manager stated Resident #10's Clonazepam was returned on 8/21/24. He reported the medication would be sent by the pharmacy to the facility on 8/30/24.	F 755		

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F 755	Continued From page 178 An interview was conducted with the facility's Corporate Nurse Consultant who stated the controlled substance log was not able to be located for Resident #10. He further stated when Resident #10 requested his medication staff should have ensured the medication was available.	F 755		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, pharmacist interview, and physician interview the facility failed to ensure Protimes/	F 757	F757 Corrective actions accomplished for those residents found to be affected by the	10/14/24

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F 757	Continued From page 179 International normalized ratios (INRs) were completed per orders for a resident receiving Coumadin. This was for one (Resident # 2) of one sampled resident receiving Coumadin. The findings included: Resident # 2 was admitted to the facility on 10/27/23. One of the resident's diagnoses included atrial fibrillation. (Atrial fibrillation is a heart arrhythmia and can lead to ineffective blood pumping by the heart which then can subsequently lead to blood pooling in the heart chambers and thereby forming clots.) Review of July 2024 physician orders revealed an order transcribed onto the MAR (medication administration record), dated 7/1/24, for Coumadin 2.5 milligrams one time daily on Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday for the diagnosis of Atrial Fibrillation. According to the order the resident was not to receive the Coumadin on Mondays. (Coumadin is an anticoagulant and helps prevent blood clots). On 7/1/24 there was also an order created in the electronic system on 7/1/24 for weekly Protimes and INRs (international normalized ratios) to be done weekly on Mondays. (These lab values reflect how long it takes a person's blood to clot and are typically drawn for individuals receiving an anticoagulant. They can help the physician determine therapeutic Coumadin dosage). According to the electronic order the next Protime/INR was to be drawn on 7/8/24. A review of Resident # 2's July MAR (Medication Administration Record) revealed between the dates of 7/2/24 (Tuesday) to 7/7/24 (Sunday)	F 757	deficient practice: Resident #2 was assessed by the attending physician on 09/13/2024. No negative outcomes were identified following missing monitoring of medication. Attending physician discontinued Coumadin for resident #2 on 9/13/2024. Identification of other residents having the potential to be affected by the same deficient practice: All residents with orders for Coumadin/Warfarin have the potential to be affected. 100% audit of all current residents with current orders for coumadin/Warfarin (medication that can break down existing clots or prevent clots from forming in body), completed by the DON, ADON, and/or unit coordinator (#1 or #2) to ensure adequate monitoring of those medication took place per manufacturer recommendations. The audit was completed on 10/07/2024. Any identified discrepancies were addressed by DON, ADON, and/or unit coordinator (#1 or #2). Findings of this audit are documented on the anticoagulant order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: On 09/13/2024, Regional Director of Clinical services implemented the Warfarin/Coumadin tracking form, the tool is utilized to track each resident on Coumadin/Warfarin order, to include resident name, dose of coumadin	

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Continued From page 180

Resident # 2 was documented as receiving the ordered Coumadin on the following dates: 7/3/24; 7/5/24; 7/6/24; and 7/7/24.
Review of labs revealed no Protime/INR done on 7/8/24 (Monday) as ordered for Resident # 2.

Review of Resident # 2's July 2024 MAR revealed between the dates of 7/9/24 (Tuesday) and 7/14/24 (Sunday) Resident # 2 was not documented as receiving any Coumadin.

On 7/15/24 the first Protime/INR in July 2024 was done. The Protime result was 58.1 and the INR was 6.75. The lab report noted the INR therapeutic range for prevention of deep vein thrombosis (clots) was 2.0 to 3.0. The lab report also noted Resident # 2's 7/18/24 value was a critical value and the result was called to a facility staff member on 7/15/24 at 3:59 PM.

On 7/15/24 (Monday) at 4:44 PM former Unit Manager # 2 documented the physician was notified regarding Resident # 2's Protime and INR and orders received to hold the coumadin and to repeat the INR the next day (7/16/24).

According to Resident # 2's July 2024 the Coumadin was not administered on 7/16/24 (Tuesday).

Record review revealed no Protime/INR was drawn on 7/16/24 as the Unit Manager had indicated the physician wanted in the nursing notes.

On 7/16/24 an order was placed in the electronic record for PT/INR weekly on Mondays.

On 7/17/24 a revision order was placed in the

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ordered, current PT/INR results new dose ordered, and next date for PT/INR. The coumadin tracking sheet is effective from 09/13/2024.
Effective 10/07/2024, the facility□s nursing administrative team, which includes the DON, ADON, Unit coordinators (#1, #2), and/or wound nurse, incorporated the process for reviewing coumadin tracking log to validate each resident has a proper monitoring per physician order. This systemic process will take place Monday through Friday. This process will be incorporated into the clinical meeting taking place Mondays to Fridays. Any identified issues will be addressed promptly by the DON, ADON and/or Unit Coordinators #1 or #2.

100% education of all Licensed nurses and Medication aides to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but is not limited to, the importance of ensuring residents on coumadin has proper monitoring in place by reviewing the last INR before administering coumadin per physician order. Staff education also focused on the use of the Coumadin/Warfarin tracking tool and its importance to ensure proper monitoring per physician orders and manufacturer recommendations. This education will be completed by 10/14/24. Any Licensed nurse and/or medication

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F 757	Continued From page 181 electronic record for PT/INR one time only for repeat critical lab value. (This order showed as a revision date of 7/17/24) According to the July MAR Resident # 2 was documented as receiving his Coumadin dosage of 2.5 mg on 7/17/24. Review of lab results revealed on 7/18/24 the first Protime/INR was completed following the completion of the 7/15/24 critical lab result. On 7/18/24 the resident's PT was 67.6 and INR was 7.99. This 7/18/24 lab report noted these values were again critical. On 7/18/24 Resident # 2 was ordered to receive Vitamin K 5 mg (milligrams) stat (right away) subcutaneously (SQ) one time for a supratherapeutic INR. (The administration of Vitamin K helps normalize elevated INR values). According to the July 2024 Resident # 2 received the Vitamin K on 7/18/24 and he did not receive any Coumadin. On 7/19/24 at 8:31 AM a nursing entry included documentation there was an order to hold Resident # 2's Coumadin until further notice, another PT and INR were to be completed, and to give Vitamin K 5 mg SQ that day. On 7/19/24 an order was entered into the electronic record for Resident # 2 to have a PT/INR. On /19/24 at 10:00 AM the Assistant Director of Nursing (ADON) documented in the nursing notes she administered the Vitamin K as ordered.	F 757	aide not educated by 10/14/24 will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new Licensed nurses and medication aides effective 10/14/2024 Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/07/2024, DON and/or ADON will monitor compliance with monitoring of medication to include anticoagulant therapy by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team validate the use of Coumadin/Warfarin tracking log and ensure PT/INR were obtained per physician orders. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation. Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	

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F 757	Continued From page 182 Review of lab results revealed on 7/19/24 Resident # 2's Protime was 87.9 and his INR was greater than 9.75. This lab report noted the values were critical. According to hospital records the resident was sent to the hospital on 7/19/24 and arrived at 6:10 PM that evening. The ED (Emergency Department) physician noted the following. The resident was sent to them for evaluation of his supratherapeutic INR and his Coumadin had been held in previous days. Resident # 2 denied any active bleeding. There were no obvious signs of bleeding upon assessment. The INR was repeated in the ED and found to be 4.5. The resident would be discharged with a plan to hold his Coumadin and for the INR to be rechecked in the next 24 to 48 hours. According to the hospital records, Resident # 2 was discharged from the ED back to the facility at 7:27 AM on 7/20/24. According to the July 2024 MAR Resident # 2 was documented to receive his Coumadin on 7/21/24. Review of lab results revealed the PT/INR was next drawn on 7/22/24 (Monday) and the result was a PT of 12.2 and an INR of 1.19. According to Resident # 2's July 2024 MAR he did not receive any Coumadin on 7/22/24 or 7/23/24. On 7/24/24 Resident # 2 was documented to receive Coumadin 2.5 mg. On 7/24/24 at 8:03 PM a nursing entry noted the provider was notified of the PT/INR of 12.2 and 1.19. (This was the result that had been drawn two days prior on 7/22/24.) The nurse further	F 757		

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F 757	Continued From page 183 noted there was an order at that time to start Coumadin 1 mg every day on 7/25/24. Review of orders revealed an order dated 7/24/24 for Coumadin 1 mg every day. Review of Resident # 2's July 2024 MAR between the dates of 7/25/24 through 7/30/24 revealed Resident # 1 received Coumadin 1 mg on all the dates excluding 7/26/24, on which date there was no documentation he received Coumadin. A nursing note, dated 7/30/24 at 11:39 PM included documentation that Resident # 2's PT was 12 and the INR was 1.17 and the physician was notified. This value indicated the resident's level was subtherapeutic and it did not show on a lab result filed in the resident's record. Review of orders revealed on 7/31/24 an order by the Nurse Practitioner was given for a Stat PT/INR to be done on 7/31/24. On 7/31/24 at 6:38 PM Unit Manager # 2 documented the resident's physician canceled the stat order and ordered the resident receive Coumadin 3 mg times three days and to continue to check the resident's PT/INR on a weekly basis. On 7/31/24 an order was given for Coumadin 3 mg through 8/3/24. Review of lab results revealed on 8/1/24 a PT result of 14.1 and an INR result of 1.27. According to Resident # 2's July 2024 and August 2024 MAR, the resident received Coumadin 3 mg from 7/31/23 through 8/3/24. Review of orders revealed an order dated 8/2/24	F 757		

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F 757	Continued From page 184 to start Coumadin 1.5 mg. Review of the record revealed no PT/INR was drawn on 8/8/24 which would have corresponded to the weekly draw time from the resident's last PT/INR of 8/1/24. Review of labs revealed a PT/INR on 8/9/24 with a result of PT 16.9 and INR 1.71 Review of orders revealed an order dated 8/10/24 to give a one time extra dose of 1 mg coumadin. In the directions of the order the one time dose was to be given "tomorrow". According to Resident # 2's August 2024 MAR he was documented as receiving Coumadin 1.5 mg from 8/3/24 through 8/13/24 excluding the dates of 8/6/24 and 8/7/24 and 8/10/24. On 8/10/24 there was documentation the resident received the additional dose of 1 mg with his 1.5 mg. On the dates of 8/6/24 and 8/7/24 the resident was documented to receive only .5 mg rather than 1.5. According to the MAR, the nurses documented on the MAR separately for the 1 mg dose and the .5 mg dose to make the total dose of 1.5 mg and on the dates of 8/6/24 and 8/7/24 the staff only documented under the Coumadin .5 mg that it was administered. Review of lab results revealed on 8/12/24 Resident # 2's PT/INR was drawn which indicated it was drawn earlier than the weekly draw which was due on 8/16/24 after being drawn on 8/9/24. The result was a PT of 16 and an INR of 1.61. Review of orders revealed an order on 8/14/24 to start Coumadin 2 mg every day.	F 757		

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F 757	Continued From page 185 According to Resident # 2's August 2024 MAR the resident received this Coumadin 2 mg dosage between the dates of 8/14/24 and 8/20/24 excluding the two dates of 8/14/24 and 8/17/24. On these two dates the resident was not documented to receive Coumadin. Review of orders revealed an order on 8/14/24 to recheck a PT/INR in one week on 8/21/24. Review of lab results revealed the PT/INR was completed early on 8/16/24. The result was a PT of 15.1 and an INR of 1.51. Review of orders revealed on 8/20/24 an order was given to administer Coumadin 3 mg daily. According to Resident # 2's August 2024 MAR the resident's Coumadin was not checked off as being administered on the dates of 8/20/24 and 8/21/24. Review of lab results revealed on 8/19/24 Resident # 2's PT was repeated earlier than the ordered 8/21/24. The PT result was 18.2 and the INR was 1.7 on a lab report which showed "printed on 8/19/24 at 9:50 PM." Review of orders revealed on 8/21/24 Resident # 2 was ordered to receive Coumadin 4 mg daily from 8/22/24 until 8/24/24. According to the August 2024 MAR Resident # 2 received this dosage from 8/22/24 through 8/24/24. According to orders and the August 2024 MAR from 8/25/24 through 8/30/24 there was no Coumadin documented as ordered or	F 757		

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F 757	Continued From page 186 administered. Review of orders revealed Resident # 2 was ordered to have a PT/INR repeated on 8/26/24. Review of lab results revealed on 8/26/24 the PT/INR was completed and was 13.5 and 1.34. On 8/30/24 Resident # 3's Coumadin was restarted at 4 mg every day. The facility pharmacy consultant was interviewed on 8/30/24 at 2:55 PM and reported the following information. During her July monthly review, the resident's weekly Protime had not been due yet to be drawn and therefore she had not reported a problem. She had reported a problem the following month (August 2024) about the timing of labs to the physician. The best practice for Coumadin was for the Protime/INR to be drawn and then the physician consulted when the result was known so that determinations could be made about timing of lab redraws and Coumadin dosing. Resident # 2's physician was interviewed on 8/30/24 at 4:35 PM and reported the following information. No harm had ever come to the resident from the elevated Protimes. The resident had not experienced bleeding or bruising. At times it cannot be determined why the levels might go up. He was aware the facility had undergone a new electronic medical system and now he was able to look in the record and see the results. This made it easier for him to keep better track of the levels. For Resident # 2 weekly PT/INRs would be sufficient. He was not sure why they had been drawing them more often recently. It could be that one of his fellow	F 757		

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F 757	Continued From page 187 collegues visited, the nurse made his collegue aware of the result, and the collegue ordered a PT/INR while not being apprasied by the facility nurse that the resident was already on weekly PT/INR orders. Interview with the facility Corporate Nurse Consultant on 8/30/24 at 3:20 PM revealed the following information. The documentation on the MAR indicating the days and dosages of Coumadin given may not be reflective of the actual administration. This was because the facility had transitioned to a new medical electronic record system, and they had identified documentation issues on the MARs. Administration was working to correct the documentation issue and develop a better tracking system for Protime lab results to be tracked.	F 757		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents and staff the facility failed to ensure a system where residents who preferred and requested larger portions received	F 806	F806 Corrective actions accomplished for those residents found to be affected by the deficient practice:	10/14/24

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F 806	Continued From page 188 the portions per their preference without having to go to the dietary department and ask for more food. This was for two (Residents # 9 and # 11) of six sampled residents reviewed for dietary services to meet their preferences and needs. The findings included: 1. Resident # 9 was admitted to the facility on 9/5/24 with multiple diagnoses which in part included congestive heart failure and diabetes. Review of Resident # 9's admission Minimum Data Set assessment, dated 8/21/24, revealed the resident had moderate cognitive impairment. A review of Resident # 9's diet orders revealed an order, dated 8/15/24, for a diabetic regular diet. The order did not note any preferences for larger portions. A review of Resident # 9's care plan, dated 8/16/24, revealed the resident's dietary preferences were to be reviewed as needed for the resident. Review of the facility's RD (registered dietician) note, dated 8/19/24, revealed the resident's weight was 171 pounds and he was 68 inches tall. The RD noted the resident had complained of hunger per the staff and she (the RD) recommended double portions of protein and vegetables at meals and snacks if the resident preferred and if he continued to complain of hunger between meals. Resident # 9 was initially interviewed on 8/28/24 at 9:50 AM and reported he was supposed to get double portions of food and the staff did not always serve him the double portions.	F 806	Resident #9 no longer in the facility, no other actions taken for resident #9 Resident #11 registered dietician recommendation for double portion implemented on 8/31/2024. Identification of other residents having the potential to be affected by the same deficient practice: 100% of all registered dietician recommendation for current residents given in the last 30 days were audited on 10/07/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other recommendations that were not transcribed/implemented correctly in the facility. Findings of this audit are documented on the F806 audit tool located in the facility compliance binder. The dietary manager has interviewed all residents listing double portions to ensure that they are receiving double portion as indicated. This audit was complete on 10/2/2024. The dietary manager completed 100% interview for all current residents to determine their likes and dislikes to include the preference of double portion of meals and updated the dietary tickets to reflect each resident�s preferences. This audit was complete on 10/7/2024. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 10/7/2024, the registered dietician and/or Dietary manager will interview the new admission to determine each resident�s food preferences to	

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On 8/29/24 at 9:00 AM Resident # 9 was observed to have regular portions of breakfast food items. His tray card made no mention of his preference for double portions.

Interview with the RD on 9/4/24 at 10:12 AM revealed she had recommended double portions because of the resident's complaints of hunger. She sent the recommendation to several administrative staff members. One of the staff members who received the dietary recommendation was the DM (dietary manager).

The DM was interviewed on 8/30/24 at 8:34 AM and reported he had spoken to the resident and knew the resident preferred to have double portions. He (the DM) was waiting for the registered dietician to evaluate the resident to confirm changing his diet orders to include larger portions. The DM did not seem aware of the recommendation of the RD from 8/19/24.

Interview with the Corporate Nurse Consultant on 8/31/24 at 11:00 AM revealed the facility had been giving Resident # 9 food so he would not be hungry. The resident had been going to the kitchen and asking for the additional portions and the facility had now updated his preferences to note that he should automatically receive the extra food without having to go ask for it.

2. Resident #11 was admitted to the facility on 10/8/21.

Review of Resident # 11's quarterly Minimum Data Set assessment, dated 5/29/24, revealed the resident was cognitively intact.

F 806

include the preference for double portion of meals. The registered dietician and/or dietary manager will update the meal tickets and implement resident preferences as indicated.
Effective 10/7/2024 the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2), revised the process for reviewing Registered dietician recommendations written in the last 24 hours or from the last held clinical meeting to ensure such recommendations, including the recommendation for double portions, are transcribed correctly in facility electronic medical records and resident□s tray card. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.

On 10/07/2024, the facility Dietary Manager established a process for detail review of tray cards during the tray line to ensure resident□s preferences to include preference for double portions are reviewed and implemented, this process include one staff member will read the tray card to include whether resident need a double portion or not for the second staff member to serve mentioned food to the plate, that will be verified by the third person before placed on the cart.
100% education of all current facility

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F 806	Continued From page 190 A review of Resident # 11's diet orders revealed an order, dated 7/2/24, for a heart healthy regular diet with thinned liquids. The order noted double portions. Resident # 9 was interviewed on 8/28/24 at 10:09 AM and reported he was supposed to get double portions of food, and the staff did not always serve him the double portions. On 8/30/24 at 12:45 PM Resident # 11 was observed to have regular portions of food items. There was one fish sandwich on his tray. His tray card specified double portions. During an interview with Nurse Aide #3 on 8/30/24 at 12:50 PM she stated the portion on Resident #11's tray was not a double portion. An interview and observation were conducted with the Dietary Manager on 8/30/24 at12:54 PM. He stated Resident #11 did not receive a double portion and he felt like it was an oversight at the end of the tray line.	F 806	Dietary employees to include full-time, part-time, and as needed employees will be completed by the Dietary Manager. The emphasis of this education includes, but not limited to the importance of ensuring resident meals are served following the tray cards to include honoring resident□s preferences for double portion. The education also emphasized the new tray line process that will ensure resident□s tray tickets are followed appropriately. This education will be completed by 10/14/24. Any dietary employee not educated by 10/14/24, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new dietary employees effective 10/14/24. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of reviewing discharge summaries for any dietary orders and or preferences and ensure they are communicated to the dietary department for implementation. The education also emphasized the importance of following registered dietician recommendation timely. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.	

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F 806	Continued From page 191	F 806	Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all registered dietician recommendations during weekly meetings to ensure the recommendations were carried out. Any negative findings will be corrected promptly. This monitoring process will be completed weekly for four weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the RD recommendation monitoring tool for new residents located in the facility compliance binder. Effective 10/07/2023, the Dietary Manager, kitchen manager or designee will complete food serving monitoring process by observing tray line on one meal a day to ensure; residents food preferences including double portion are served per tray card. This monitoring process will be completed daily (Monday through Fridays) for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Food serving monitoring tool located in the facility compliance binder. Effective 10/14/2024, Director of Nursing Dietary Manager and/or Kitchen manager will report findings of this monitoring	

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F 806	Continued From page 192	F 806	process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview the facility failed to provide	F 825	F825 What corrective actions will be	10/14/24

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F 825	Continued From page 193 rehabilitation services per the resident's plan of care. This was for one (Resident # 16) of three sampled residents reviewed for therapy services. The findings included: Resident # 16 was admitted to the facility on 6/17/24 following a fourteen day hospitalization. According to a hospital discharge summary dated 6/17/24 the resident was found to be treated for acute ulcerative esophagitis, upper gastrointestinal bleeding, and a urinary tract infection while hospitalized. Additionally, the resident had diagnoses in part which included a hiatal hernia, urinary retention, congestive heart failure, chronic obstructive pulmonary disease, seizure disorder, and hypertension. According to the 6/17/24 discharge summary Resident # 16 was to have physical therapy upon discharge. Resident # 16's Minimum Data Set assessment, completed on 6/20/24, coded the resident as moderately cognitively impaired. The resident was assessed to need partial to moderate assistance with his hygiene and bathing needs. Review of therapy documentation revealed Resident # 16 was initially evaluated by physical therapy on 6/19/24 and his treatment plan included therapy sessions for five times per week for four weeks. His therapy certification was from 6/19/24 to 7/18/24. Therapy goals set for the resident included working on transfers, walking, and navigating steps. Review of physical therapy June 2024 service logs revealed physical therapy staff members logged they provided physical therapy treatment hours on four of the twelve days between 6/19/24 to 6/30/24. This was on 6/19/24; 6/20/24; 6/24/24;	F 825	accomplished for those residents found to be affected by the deficient practice? Resident #16 is no longer in the facility. Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of all current residents who receive therapy services completed on 10/07/2024, by the Director of Rehabilitation to identify any other resident who missed therapy services per order/plan of care in the last 30 days. Any resident(s) identified with missing therapy per plan of care will be reassessed to ensure no negative outcomes resulted from missing rehab. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 10/07/2024, facility rehabilitation employees will ensure residents receives specialized rehabilitative services as determined by their comprehensive plan of care to assist them to attain, maintain or restore their highest practicable level of physical, mental, functional and psycho-social well-being. This systemic modification will be accomplished by implementing the following measures: Effective 10/07/2024, the Clinical team, which consists of the DON, ADON, MDS, Rehab Director, and social worker will review 100% of new admissions to ensure that each resident is screened by therapy staff to determine the need for rehabilitation services, and if so ensure that the plan of care for such services is	

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F 825	Continued From page 194 and 6/26/24. Between the dates of 7/1/24 to 7/18/24 physical therapy members logged they provided physical therapy hours on ten days of the eighteen- day period. These were 7/1/24 to 7/5/24; 7/8/24; 7/10/24 to 7/12/24; and 7/16/24. On 7/22/24 an updated physical therapy plan was devised and the therapy department received approval/certification for the resident to receive physical therapy from 7/22/24 through 8/19/24. The resident's treatment plan again included physical therapy services for five times per week for four weeks. Review of physical therapy July 2024 service logs revealed physical therapy staff members logged they provided physical therapy treatment hours one time between the time of 7/22/24 through 7/31/24. This was on 7/22/24. Review of physical therapy August 2024 service logs revealed physical therapy staff members logged they provided physical therapy treatment hours ten days out of nineteen days from 8/1/24 to 8/19/24. These were on 8/6/24 through 8/9/24; 8/12/24 through 8/16/24; and on 8/19/24. Interview with Resident # 16's RP (Responsible Party) on 8/28/24 at 3:29 PM revealed Resident # 16 had not always received physical therapy per his plan of care. The RP had asked about this and been informed the therapy department had been short of therapists. The RP was concerned about this and his goal was for the resident to eventually go home with assistance after rehabilitation. The Rehabilitation Director was interviewed on 8/30/24 at 8:15 AM and again on 8/31/24 at 8:10	F 825	developed and implemented timely. Additionally, if there are recommendations on the discharge summary pertaining to therapy services, the therapy director will share these recommendations with her therapists who evaluate residents on admissions. 100% education of all therapy staff, to include full time, part time, and as needed therapy employees will be completed by the Director of Rehabilitation services. The emphasis of this education includes but not limited to the importance of; screening all new admission for the need of specialized rehabilitation services, and ensuring each resident who need therapy services, receives such services based on individual plan of care. This education will be completed by 10/14/2024. Any therapy employee not educated by 10/14/24 will not be allowed to work until educated. This education will be provided for any newly hired therapy employees during the new hire orientation, and annually. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/7/2024, the Administrator, and/or Director of Rehabilitation services will complete the monitoring process to ensure residents received necessary care to include specialized rehabilitation services based on plan of care. This monitoring process will be accomplished by implementing the following measures: Effective 10/7/2024, during the clinical meeting, the rehab director will cross reference discharge summary orders	

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F 825	Continued From page 195 AM and reported the following information. She confirmed that Resident # 16 had not received therapy per his plan of care which was based on a licensed therapists' evaluation of his needs. She (the Rehabilitation Manager) had returned to work on 7/22/24 after an extended leave of absence. During her time away from the facility, a therapist from a sister facility was supposed to be handling problems related to staffing issues that might arise. When she (the Rehabilitation Manager) returned she immediately recognized that they needed more staff. There had been therapy staff members out of work due to illness sick and open therapy positions. She made her regional director aware of the problem and met with her. They immediately devised a plan and had worked on filling the open positions and creating some new positions also to ensure residents were receiving therapy per their plan of care. Interview with the corporate Nurse Consultant on 8/31/24 at 12:00 PM revealed that there had been no formal auditing of therapy through the facility's formal quality assurance program to ensure the problem was totally rectified although the rehab director had taken proactive steps to resolve the staffing issue and felt that all residents were again receiving therapy as indicated. A review of Resident # 16's physical therapy notes revealed the resident had again been certified to receive physical therapy services from 8/21/24 to 9/17/24, was receiving therapy as his evaluation indicated, and had made progress towards his goals.	F 825	pertaining to therapy recommendations in the facility electronic health record system to ensure they are accurate and correct. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 10/07/2024, the Director of Rehabilitation services will review resident□s therapy schedule for services provided in the last 24 hours or from the last clinical meeting to ensure each resident receive such care per the plan of care. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of Rehabilitation services promptly. This monitoring process will be documented on a service log matrix located in the facility compliance binder. Effective 10/07/2024, Director of Rehabilitation services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	
F 842 SS=E	Resident Records - Identifiable Information	F 842		10/14/24

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F 842	Continued From page 196 CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(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(h)(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 197 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(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 staff interview and record review the facility failed to accurately and consistently document vital signs, blood glucose readings, and medication administration for two (Resident #22 and Residnet #13) of three residents reviewed for accuracy of medical record documentation. Findings included: Documentation in a physician order dated 6/22/2024 revealed Resident #22 was ordered to	F 842	F842 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #13 no longer in the facility, no other actions taken for resident #13 Resident #22 no longer in the facility, no other actions taken for resident #22 Identification of other residents having the potential to be affected by the same	

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F 842

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receive Novolog insulin solution to be injected subcutaneously (under the skin) three times day at 8:00 AM, 12:00 PM, and 4:00 PM per the following sliding scale: If the blood glucose level was 201 milligrams per deciliter (mg/dL) to 250 mg/dL administer 4 units; 251 mg/dL to 300 mg/dL administer 6 units; 301 mg/dL to 350 mg/dL administer 8 units; 351 mg/dL to 400 mg/dL administer 10 units; greater than 400 mg/dL call the physician. Novolog is a fast-acting insulin used to treat high blood glucose for people with diabetes.

Documentation on the July Medication Administration Record (MAR) for Resident #22 revealed on 7/9/2024 the blood glucose level was 399 mg/dL and Medication Aide (Med Aide) #5 administered ten units of insulin at 6:22 PM.

Med Aide #5, an agency employee, was interviewed on 9/5/2024 at 1:08 PM and revealed the following information. Med Aide #5 confirmed she did take the blood glucose reading of 399 mg/dL on 7/9/2024 and that she did not administer insulin to Resident #22. Med Aide #5 did not recall who the licensed nurse was who was assigned to help her perform medication administration tasks out of her scope of practice on 7/9/2024. Med Aide #5 explained when she put the blood glucose reading into the electronic MAR, the administration of the insulin would also incorrectly go under her name. Med Aide #5 indicated she had to trust that the licensed nurse, to whom she reported the blood glucose level of Resident #22, would administer the correct insulin dose and document the administration under their name.

There was no documentation on the July MAR

F 842

deficient practice:
100% audit of all current resident□s blood glucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation of a high blood glucose documented with no appropriate intervention to include administration of ordered insulin. Any resident(s) identified with missing documentation of administration of insulin as ordered, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered.

100% audit of current residents with orders for levothyroxine was completed by the DON, ADON, and unit coordinator (#1 or #2) to ensure ordered medication were administered per physician orders in the last fourteen days. The audit was completed on 10/7/2024 & 10/08/2024. Findings of this audit is documented on the levothyroxine medication audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur

Effective 10/07/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe/document all orders to resident□s medical records to include orders for levothyroxine and insulin.

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Resident #22 had a blood glucose level taken or received Novolog insulin as ordered at 8:00 AM on 7/10/2024.

Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered 10 units of Novolog insulin on 7/10/2024 at 1:43 PM to Resident #22.

There was no documentation on the July MAR Resident #22 had a blood glucose level taken or was administered Novolog insulin as ordered at 4:00 PM on 7/10/2024.

An interview was conducted with Med Aide #4 on 9/6/2024 at 1:54 PM. Med Aide #4 confirmed she was assigned to the hallway which Resident #22 resided on 7/10/2024 for the 7:00 AM to 7:00 PM shift. Med Aide #4 revealed she was told by Nurse #4 that she had already administered medications to Resident #22 on the 7:00 PM to 7:00AM shift ending on 7/10/2024. Med Aide #4 stated she expected Nurse #4 to document on the MAR the medications she was told had already been administered as an explanation for why there was no documentation of the Novolog insulin for Resident #22 at 8:00 AM on 7/10/2024. Med Aide #4 explained that she could not remember which licensed nurse was assisting her on 7/10/2024 and confirmed she did not administer Novolog insulin to Resident #22 on 7/10/2024 at 1:43 PM. Med Aide #4 thought the licensed nurse, assisting her on 7/10/24, was Unit Manager #2. On 7/10/2024 the blood glucose level for Resident #22 read as "HI" or above 400 mg/dL on the glucose monitor. (A reading of "HI" on a glucometer means the reading is above the level readable by the glucometer.) The licensed nurse told Med Aide #4 the physician ordered 12

F 842

Effective 10/07/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing new admissions/readmission to ensure that the medication orders and other orders on the discharge summary, match the orders that are entered into the facility Electronic Health Records (EHR). Additionally, if there are recommendations on the discharge summary that are not reflected in the discharge orders, the clinical team will ensure the clarification is obtained from the discharging facility and/or resident□s attending physician. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.

Effective 10/07/2024, facility employees will document the administration of medication based on physician orders to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record.
Effective 10/07/2024, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit coordinator #1 or #2 revised the shift change process to provision for validating the administration of all medication including insulin and levothyroxine by

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F 842	Continued From page 200 units of Novolog insulin to be administered to Resident #22 and to keep checking the blood glucose level every hour. Med Aide #4 kept checking the blood glucose level every hour and reported to the licensed nurse the reading was still registering as above 400 mg/dL. Med Aide #4 thought the licensed nurse was going to document everything and take care of the 4:00 PM scheduled Novolog insulin administration on 7/10/2024 because of the blood glucose readings that were over 400 mg/dL, requiring a physician to be involved. Med Aide #4 revealed the MAR did not allow Novolog insulin to be checked off as administered unless an actual number was entered into the MAR for the blood glucose reading. Med Aide #4 stated she had to put in 400 mg/dL although the reading may have been over 400 mg/dL. Unit Manager #2 was interviewed on 9/10/2024 at 8:21 AM. Unit Manager #2 revealed the following information. Unit Manager #2 revealed she thought she sent a text to the physician for Resident #22 informing him of the elevated blood glucose levels on 7/10/2024. Unit Manager #2 revealed she kept a small notebook with notes on which residents she had to go back and complete documentation on as a late entry. Unit Manager #2 thought perhaps Resident #22 having elevated blood glucose levels was one of those residents, but she forgot to go back and document. There was no documentation on the July MAR of a blood glucose level taken or Novolog insulin was administered as ordered at 8:00 AM on 7/11/2024 to Resident #22. The facility nursing schedule dated 7/11/2024 indicated Nurse #7 was assigned to the hallway	F 842	ensuring no omission are on the Medication administration Records. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring medication and other orders in discharge summaries are transcribed and administered per physician order for each resident. The education also emphasized on the shift change process that include the importance of validating no omission on medication administration records at the beginning of each shift. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for insulin, levothyroxine, and other medications to ensure Licensed nurses and medication aides are administering such medication per physician orders. This monitoring process	

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F 842	Continued From page 201 for which Resident #22 resided for the 12 hour "day shift (7:00 AM to 7:00 PM)." Nurse #7 was interviewed on 9/5/2024 at 2:37 PM. Nurse #7 stated she was an agency nurse who only worked at the facility on one occasion and that was 7/11/2024. Nurse #7 stated she did not recall what hall she was assigned to. Nurse #7 stated when she arrived at 7:00 AM on 7/11/2024, the scheduler handed her a stack of paper MARs and told her to go to the hall to begin the medication pass. Nurse #7 explained she was told she would not have access to the electronic medical record system. Nurse #7 revealed it was "chaos", but she stayed. Nurse #7 revealed she did not get login information for the electronic medical record system until approximately 2:30 PM. An interview with the medical records supervisor was conducted on 8/30/2024 at 12:10 PM. The medical records supervisor confirmed the paper MARs that were used by the facility in July 2024 as documentation of medications administered to residents were lost and never located. Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 11:47AM to Resident #22. Documentation on the July MAR revealed Med Aide #4 took a blood glucose level of 400 mg/dL and administered ten units of Novolog insulin on 7/11/2024 at 4:51 PM. During the interview conducted with Med Aide #4 on 9/6/2024 at 1:54 PM she stated she was assigned on 7/11/2024 for the 7:00 AM to 7:00	F 842	will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication review monitoring tool located in the facility compliance binder. Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication administration monitoring process. This monitoring process will be accomplished by reviewing medication administration audit report ensure no resident is listed with missing medication administration. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication administration monitoring tool located in the facility compliance binder. Effective 10/07/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial	

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F 842	Continued From page 202 PM shift to another hall next to the hall which Resident #22 resided. Med Aide #4 revealed everything was "a mess" on the hallway which Resident #22 resided because there was an agency nurse (Nurse #7) who was trying to figure out the paper MAR and she was not giving medications. Med Aide #4 revealed the agency nurse (Nurse #7) left and was put on the do not return list. Med Aide #4 confirmed she took the blood glucose readings for Resident #22 on 7/11/2024 at 11:47 AM and 4:51 PM. Med Aide #4 revealed that some of the blood glucose readings for Resident #22 were actually registering as HI or over 400 mg/dL while at least one of the readings she documented on the MAR on 7/11/2024 was actually 400 mg/dL. Med Aide #4 explained the licensed nurses were going into the MAR after she documented the blood glucose reading and using her login credentials to document the administration of insulin, so it was not recorded who the licensed nurse was who administered insulin to Resident #22. Documentation in the physician orders revealed an order dated 7/11/2024 at 7:00 PM for Resident #22 to be administered ten units of Humalog insulin solution to be injected subcutaneously one time only for a blood glucose exceeding 400 and contact the physician in two hours. Humalog insulin is a fast-acting insulin which is absorbed quickly and starts working in about 15 minutes after injection to lower blood glucose levels. There was no documentation on the July MAR that the order for Humalog insulin was administered to Resident #22 on 7/11/2024 after 7:00 PM. Documentation in the physician orders revealed	F 842	compliance. Compliance date: 10/14/2024.	

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F 842	Continued From page 203	F 842		

an order dated 7/11/2024 at 9:00 PM for Resident #22 to be administered ten units of Novolog insulin solution subcutaneously one time for blood glucose exceeding 400 mg/dL and contact the physician in two hours.

There was no documentation on the July MAR that the one-time order for Novolog insulin was ever administered to Resident #22 on 7/11/2024 after 7:00 PM.

There was no other documentation in the electronic medical record of any vital signs taken of Resident #22 on 7/11/2024.

Documentation in the nursing notes for Resident #22 dated 7/12/2024 at 9:48 AM by Nurse #4 revealed, "Physician contacted due to blood glucose exceeding 400 (mg/dL) and order received from physician to administer 10 [units] of Humalog or Novolog and report back after 2 hours. After 2 hours, resident blood [glucose] reading still exceeded 400 (mg/dL) and physician made aware of results. Family arrived and RP requested for resident to be sent to [emergency room] for evaluation. Physician made aware and order received to send resident to [emergency room]. DON made aware."

An interview was conducted with Nurse #4 on 9/5/2024 at 6:04 PM. Nurse #4 stated she started her 7:00 PM to 7:00 AM shift at 7:00 PM on 7/11/2024. Nurse #4 received the information in a nursing report from Med Aide #4 that the blood glucose level of Resident #22 was above 400 mg/dL on the 4:00 PM medication pass. Nurse #4 stated she assessed Resident #22 and took her vital signs at the start of her shift. Nurse #4 revealed the blood glucose level of Resident #22

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F 842	Continued From page 204	F 842		

was registering as High or over 400 mg/dL on the glucometer, a device to measure blood glucose levels. Nurse #4 revealed the vital signs of Resident #22 were fine, so she called the on-call physician. Nurse #4 stated she received an order from the physician to administer 10 units of fast acting insulin to Resident #22 and call the physician back in two hours. Nurse #4 stated she went back to check on Resident #22 again at 9:00 PM and all her vital signs were fine. Resident #22 did not have a temperature, elevated blood pressure, or an elevated heart rate. Nurse #4 stated her blood glucose level was still registering as HI or above 400 mg/dL on the glucometer. Nurse #4 confirmed family came to the facility and requested Resident #22 be sent to the hospital via emergency medical services. Nurse #4 stated she did not document events in the medical record as they are happening to the residents, but documented at the end of her shift, sometimes staying late to do so. Nurse #4 indicated she may have forgotten to document all the details of the vital signs, blood glucose readings, and insulin administrations for Resident #22 on 7/12/2024.

The following blood glucose level readings were documented in the vital signs section of the medical record for July for Resident #22.

On 7/10/2024 a reading of 400 .0 mg/dL
On 7/9/2024 a reading of 205.0 mg/dL
On 7/9/2024 a reading of 200.0 mg/dL
On 7/9/2024 a reading of 399.0 mg/dL
On 7/8/2024 a reading of 178.0 mg/dL
On 7/7/2024 a reading of 151.0 mg/dL
On 7/6/2024 a reading of 176.0 mg/dL
On 7/6/2024 a reading of 176.0 mg/dL
On 7/6/2024 a reading of 191.0 mg/dL

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F 842	Continued From page 205	F 842		

On 7/3/2024 a reading of 400.0 mg/dL

There was no other documentation of any other vital signs taken for the month of July 2024 for Resident #22 in the vital signs section of the electronic medical record.

An interview was conducted with MD #2, the physician for Resident #22, on 9/9/2024 at 1:12 PM. MD #2 stated when he was reviewing charts of his residents, he did not look at the MAR to see what the blood glucose levels were for the month but looked at the vital sign section of the electronic medical record. MD #2 stated that when he looked at the vital signs for Resident #22, he saw no concerns with the blood glucose levels because there was only one reading on 7/10/2024 that was 400 mg/dL. MD #2 further stated he did not see any other concerning vital signs in July for Resident #22 therefore, he would not have concluded there was any medical emergency for that resident or concerns.

An interview was conducted with the facility Corporate Nursing Consultant on 8/30/2024 at 3:38 PM. The nursing consultant acknowledged the facility had problems with documentation in July 2024, but the facility was working toward improving procedures for documentation.

2. Resident #13 was admitted to the facility on 12/29/23 with diagnoses that included hypothyroidism.

Resident #13's quarterly Minimum Data Set (MDS) assessment dated 7/10/24 revealed she was cognitively intact.

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F 842	Continued From page 206 Review of orders for Resident #13 revealed an order dated 8/20/24 for levothyroxine sodium tablet 125 (micrograms) mcg daily on an empty stomach for low thyroid hormone. Review of Resident #13's August Medication Administration Record revealed the levothyroxine sodium tablet was not documented as given on 8/20-8/25/24, 8/27/24, and 8/28/24. During an interview with Nurse #3 on 8/31/24 at 8:33 AM who reviewed the MAR and Resident #13's levothyroxine sodium tablet card and stated she could not tell which doses may have been missed. Nurse #3 stated it appeared some doses had been missed. She clarified she had never administered this medication to Resident #13. An interview was conducted with the Corporate Nurse Consultant on 8/31/24 at 8:40 AM who stated he felt the medication was being administered and it was a documentation issue. The facility switched to a new documentation system in July and staff members have struggled to learn how to correctly document. During an interview with Nurse #4 on 8/31/24 at 9:52 AM. She reported she administered Resident #13's medication as ordered. She stated she believed the MAR was incorrect. Nurse #4 stated sometimes the internet goes down and she was not able to record medications given. She stated she had not advised any one an issue with internet service. An interview was conducted with the facility's Corporate Nurse Consultant on 8/31/24 at 10:15 AM and he stated he was not aware of any issues	F 842		

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F 842	Continued From page 207 with the facility's internet service not working properly.	F 842		
F 925 SS=G	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents, staff, family, and a pest control technician the facility failed to ensure they maintained routine and as needed pest control services for the entire facility. Two of twenty-seven sampled residents were affected by flies. Resident # 24 was observed trying to eat while four flies kept landing on her food. Resident # 1 was found by staff to have multiple maggots on her and in her bed during the timeframe during which the facility was without a service contract and during which time staff members, residents, and family were observing multiple flies in the facility. (Resident # 1 had mental illness and was unable to express harm a reasonable person would express if they had multiple maggots located on them while relying on others for care. Therefore, the reasonable person concept was applied in determining severity to this citation). The findings included: 1. Resident # 1 was admitted to the facility on 3/1/17 and had diagnoses in part which included a degenerative neuromuscular disease and bipolar disorder with psychotic features. Resident # 1's quarterly Minimum Data Set assessment, dated 6/19/24, coded Resident # 1	F 925	F925 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 head to toes skin inspection was conducted by the Unit Coordinator #1 on 10/7/2024. No new skin alterations and/or Maggots identified on resident #1, no other actions taken for resident #1 Resident #24 is no longer in the facility. On 09/06/2024, facility Administrator secured a new contract with a licensed pest control company to provide services in the facility to include controlling flies. Pest control company provide an onsite service on 09/06/2024. Identification of other residents having the potential to be affected by the same deficient practice: 100% of skin inspection for all current residents in the facility conducted between 09/19/2024, by Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2, to identify any other resident with maggot(s) in their wounds or any parts of their body. No other resident identified to have maggots on their body. Findings of this audit are documented on a skin	10/14/24

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F 925	Continued From page 208 as cognitively intact and as being totally dependent on staff for bathing, dressing, hygiene, and bed mobility. On 8/13/24 Nurse Practitioner # 1 documented she was seeing the resident, who was bedbound, because living larvae had been identified on the resident and removed. Nurse Practitioner # 1 (NP#1) was interviewed on 9/5/24 at 8:55 AM and reported the following information. She had been called on 8/12/24 and told Resident had approximately 26 maggots on her, which facility staff removed. On 8/13/24 she assessed the resident and found she had some signs of inflammation in her hand because of the maggots. From her assessment, she could tell that the maggots had been in the resident's nailbed and underneath her fingernails. She tried to talk to the resident on 8/13/24 but the resident had mental illness and was talking to nonexistent people at the time of her assessment. The resident had not been aware the maggots had been in her hand before they were identified on 8/12/24. Due to the resident's medical diagnoses, the resident did not have the sensation in the hand to detect that they had been in her hand, and she did not have the mobility to move away from flies. The resident tended to keep snacks in her room. If she had gotten some food in her hand without adequate hygiene, then flies could have landed on her hand and laid eggs. It did not take long for a fly to do this. The weekend treatment nurse was interviewed on 8/31/24 at 9:30 AM and reported the following information. On 8/11/24 MA (Medication Aide) # 1 told her Resident # 1 had some dried blood on her hand. The weekend treatment nurse also	F 925	inspection tool located in the facility compliance binder. 100% inspection for all current residents in the facility conducted on 10/07/2024, by Director of Nursing, Unit coordinator #1, Unit coordinator #2, and/or scheduler to identify any other resident with flies landing on their body while in the facility. No other resident identified to have flies landing on their body. Findings of this audit are documented on a Flies inspection tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 10/07/2024, the facility will maintain an effective pest control program so that the facility is free of pests and rodents. These systemic changes will be accomplished by implementing the following measures: Effective 10/07/2024, a licensed pest control company will provide effective post control service to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitoes, flies, mice, and rats). The company will provide routine services monthly and as needed. Effective 10/07/2024, a facility staff will report any pests or flies identified in the facility to the maintenance director through maintenance request platform. Maintenance director will contact the Pest control vendor as needed following the request of staff. Effective 10/07/2024, the Clinical team, which consists of the Director of Nursing,	

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F 925	Continued From page 209 knew that on 8/10/24 (Saturday) Nurse # 1 said that therapy had been working with the resident and her hand was bleeding. On Saturday, Nurse # 1 took care of the resident's hand because she (the weekend treatment nurse) had been busy. When she (the weekend treatment nurse) saw Resident # 1's hand on 8/11/24 (Sunday) there was no active bleeding. In her right contracted hand, the resident had fragile skin where she had previous skin breakdown. Within the fragile skin the resident appeared as if she had a very small puncture wound from her fingernails being against the palm of her skin. She (the weekend treatment nurse) used a cotton tipped swab to clean the wound and she applied a dressing. At the time she did not see any signs of maggots in the resident's hand or wound. She had seen flies in Resident # 1's room and she had also seen flies in other parts of the facility landing on people. MA # 1 was interviewed on 8/29/24 at 2:38 PM and reported the following information. She had cared for Resident # 1 both on 8/10/24 (Saturday) and 8/11/24 (Sunday). On 8/10/24 (Saturday) Resident # 1's Nurse Aide (NA) had told her that it appeared as Resident # 1's hand was bleeding. She told Nurse # 1. On 8/10/24 (Saturday) there were a lot of flies in Resident # 1's room. MA # 1 estimated there were about 12 or so flies in the room on that date. She (MA # 1) was "swishing, swishing, swishing" trying to get them away from the resident and out of her room to the best of her ability. Flies would land on the resident, who tended to keep food items resting on her chest as she ate in the bed. MA # 1 also was aware blood from the resident's hand might attract the flies to her. The maintenance director was aware flies were in the facility. It was her understanding that	F 925	Assistant Director of Nursing, DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2, will incorporate the process for reviewing completion of skin inspection to ensure that each resident has a completed skin inspection weekly and assure no maggots are identified in resident skin. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance maintaining effective pest control program and maintaining resident□s rights and treating each resident with dignity and respect including ensuring each resident is free from maggots. The education also emphasized the importance of completing skin inspection weekly, reporting any flies to the maintenance director through the maintenance request platform. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:	

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F 925	Continued From page 210 the problem with flies had been added to the maintenance log and he had been told multiple times. She (MA #1) could not go to the nursing desk and sit down without flies following her. On Sunday 8/11/24, she knew the weekend treatment nurse had cared for Resident # 1's hand and cleaned it well. She (MA # 1) never saw maggots on Resident # 1 during the weekend. MA # 2 was interviewed on 8/29/24 at 3:21 PM and reported the following information. She had been assigned to care for Resident # 1 on 8/12/24 (Monday) when the maggots were found on Resident # 1. She had started her medication pass when Resident # 1's Nurse Aide came to her and reported Resident # 1 had maggots on her. She (MA # 2) alerted a nurse who also alerted the former DON (Director of Nursing). On 8/12/24 MA # 2 had seen a fly in Resident # 1's room. Nurse Aide # 2, who had been assigned to care for Resident # 1 on 8/12/24 (Monday), was interviewed on 8/29/24 at 7:47 PM and reported she had found maggots on Resident # 1 while she was providing care. She saw flies "everywhere" in the facility and had seen them at times land on residents. Nurse Aide # 1 was interviewed on 8/29/24 at 4:40 PM and reported the following information. She had been working on 8/12/24 and had helped Nurse Aide # 2 with Resident # 1. She (NA # 2) saw multiple maggots on the resident and in her bed as she was helping care for the resident. It was her understanding the maggots had crawled out from the resident's hand. The "higher ups" (including the former DON) had been present in the room to deal with the maggots. Flies had	F 925	Effective 10/07/2024, facility Administrator and/or Assistant administrator will observe five randomly selected residents to ensure no flies are landing on their body. Any negative findings will be addressed promptly by the Administrator, Assistant Administrator, and/or Maintenance Director. This monitoring process will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 10/07/2024 DON and/or ADON will monitor compliance with completion of skin inspection by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced skin inspection schedule to assure completion and identification of any new alterations to include maggots. Any negative findings will be addressed promptly by the DON and/or ADON. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation. Effective 10/14/2024, Maintenance Director and/or Administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can	

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	345529	A. BUILDING ______ B. WING ______	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 925	Continued From page 211	F 925		

been a problem in the facility. She (NA # 1) saw them daily and they would at times land on residents.

NA # 3, who at times cared for Resident # 1, was interviewed on 8/29/24 at 12:40 PM and reported the following information. She had never witnessed maggots on Resident # 1. She saw flies "all the time" in the facility and she was aware residents complained about them.

The facility's weekday treatment nurse was interviewed on 8/30/24 at 5:15 PM and reported the following information. She (the weekday treatment nurse) had been told the resident had maggots in her hand on 8/12/24 (Monday). She had not personally seen the maggots. She had not witnessed flies landing on Resident # 1, but she had seen flies in her room. She had also seen them in the facility on a daily basis.

Resident # 1 was interviewed on 8/29/24 at 8:20 AM. At the time she was observed to have a right hand contracture. When interviewed about her care in general, the resident did not initially bring up the maggots during conversation. She tended to wander in her conversation from topic to topic. While talking about something else, she abruptly mentioned she had neuropathy in her hand and at one time had maggots in her hand. She then went off topic again and did not expound further.

The former DON, who had reportedly removed the maggots, was not available for interview during the survey.

On 8/29/24 at 1:10 PM an interview was conducted with a randomly interviewed family member of a resident (Resident # 25). This

modify this plan to ensure the facility remains in substantial compliance.
Compliance date: 10/14/2024

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F 925	Continued From page 212 resident also resided on the unit where Resident # 1 resided. The family member reported she visited often and saw flies "all the time." She further commented they would land on the resident and on the resident's food and she was constantly fanning the resident's food to keep them away. During a random observation made on a different unit (Station 2) other than the unit on which Resident # 1 resided, it was observed on 8/31/24 at 8:10 AM that a fly was hovering over the meal tray carts waiting to be served to residents on the hall. Interview with the Maintenance Director on 8/29/24 at 4:20 PM revealed he had been employed at the facility for about a month. He had not been aware there had been a problem with a specific resident having any medical issues related to flies in their room. He was aware there were flies in the facility and he had called a pest control company, and the company's technician had not visited that month as of 8/29/24. The Maintenance Director named the company he had called and indicated they would be out the next week. The Maintenance Director was interviewed about current strategies to keep flies out of the facility and reported he thought there were fly curtains (heavy duty fans that blast air away from doors which lead outside) on two to three doors. The maintenance director was accompanied as the exit doors in the facility were observed. There was one door observed to have a working fly curtain leading to the exit. There were no fly curtains on exit doors leading to the inner courtyard or on the front door of the facility. The facility's corporate Nurse Consultant was	F 925		

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F 925	Continued From page 213 interviewed on 8/30/24 at 6:00 PM. According to the Corporate Nurse Consultant the former DON had not informed the Administrator or corporate employees of any problems with the resident having maggots in her bed and on her. If the former DON had done so, the issue of flies in the building would have been addressed and a plan to prevent the problem from reoccurring would have been initiated. He had learned that day that the facility did not have a pest control contract with a service provider. When the facility recently underwent new ownership, there had been miscommunication with the pest control company and the service contract had not been extended. The facility had not had pest control services since 5/15/24 in the facility. They had called that day (8/30/24) to set services up again. The corporate Nurse Consultant reported the Maintenance Director may have called someone to come out who did not have a contract with them, while not recognizing that the contract needed to be reset with the previous company. A technician for the pest control company, which had a contract with the facility up until May 2024, was interviewed on 9/4/24 at 1:50 PM. The technician reported the following information. One of the most important things to do in controlling flies in the facility was to inspect where flies were coming from and try to eliminate a source of problems. That was part of his job when he went to facilities. Given he had not been to the facility in recent months, he was not aware from where the problem might be originating. In general, when he did go to facilities, in addition to finding and eliminating the source, he tried to install fly lights and glue boards which might bait and trap flies that might make their way into the facility. There were different kinds of flies, and at times	F 925		

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F 925	Continued From page 214	F 925		

he also considered taking a sample to differentiate what kind of fly was causing problems.

2. Resident #24 was admitted to the facility on 7/5/2024 with multiple diagnoses one of which included mild cognitive impairment.

Documentation on a skilled daily nursing documentation form dated 8/28/2024 revealed Resident #24 was assessed as oriented to person and place with a cognitive status that varied.

The following observation and interview were conducted with Resident #24 on 8/28/2024 at 1:18 PM. Resident #24 was observed to be sitting up in bed with her lunch meal in a Styrofoam container in front of her on her bedside table. Resident #24 stated, "There are always flies in here 24 hours a day, 7 days a week." Resident #24 was observed attempting to put a fork full of food into her mouth as four flies were landing on and flying around her lunch meal. Resident #24 attempted to brush the flies off her food with her hand, but the flies continued to land on her food intermittently.