STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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E 000	Initial Comments A recertification and complaint investigation survey was conducted from 03/18/24 through 03/27/24. Event ID #ZJQM11. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 03/18/24 through 03/21/24. Additional information was obtained on 03/27/24 therefore the exit date was 03/27/24. Event ID# ZJQM11. The following intakes were investigated: NC00214916, NC00214252, NC00214096 and NC00213584 1 of 7 complaint allegations resulted in deficiency.	F 000		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		4/24/24

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

Electronically Signed | 04/19/2024

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F 727	Continued From page 1 Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage on 28 of 45 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 1, 2024 (October 1-December 31, 2023) revealed the facility had no Registered Nurse (RN) coverage on 10/08/23, 11/19/23, 12/03/23 and 12/31/23. Review of the daily assignment schedules from October 1, 2023 through March 19, 2024 revealed the facility failed to provide 8 hours of RN coverage on the following dates: 10/08/23, 11/13/23, 11/14/23, 11/18/23, 11/29/23, 11/23/23, 12/03/23, 12/16/23, 12/20/23, 12/21/23, 12/22/23, 12/26/23, 12/30/23, 12/31/23, 01/13/24, 01/14/24, 01/27/24, 01/28/24, 02/10/24, 02/11/24, 02/14/24, 02/16/24, 02/15/24, 02/28/24, 03/04/24, 03/07/24, 03/29/24, and 03/10/24. In an interview with the facility Scheduler on 03/19/24 at 4:30 PM she reported the facility had been short RN coverage every other weekend for several months but could not remember how long it had been since the last RN Weekend Supervisor had resigned. She noted the facility did not use Agency staffing. She stated the facility had recently hired 2 RN's, one had started, and one was waiting to start work. In a meeting on 03/20/23 at 1:00 PM with the Payroll and Human Resources Coordinator she verified by reviewing the daily assignment sheets and payroll punches that there was no RN coverage on the 28 dates reviewed.	F 727	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The current schedule was reviewed by the Administrator on 4/18/2024. A Registered Nurse was hired on 4/18/2024 to accommodate days without RN coverage. 2. How the facility will identify other residents potentially affected by the same deficient practice Any resident has the potential to be affected. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The facility administrator completed training with the scheduler on the requirement for ensuring 8 consecutive hours of registered nurse coverage daily on 4/15/24. If there is a day on the schedule when there are not 8 consecutive hours registered nurse coverage, the scheduler is to notify the facility administrator and director of nursing (DON) immediately. A daily labor meeting will be held by the Administrator, DON and scheduler and/or unit manager to review schedules and ensure 8 consecutive hours of registered nurse coverage is scheduled daily. This meeting will be held daily 5 days /week Monday through Friday.	

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F 727	Continued From page 2 In an interview with the Administrator on 03/20/24 at 3:30 PM he stated that the facility did not have adequate RN coverage because of staff resigning. He reported that 2 RNs had changed to PRN (as needed) and a few RNs had quit. He noted that a new RN had started the previous day and was orienting. He stated a weekend RN supervisor was supposed to start the previous weekend but did not show up for work and was not returning the facility phone calls. He noted the facility was advertising on social media, had flyers in the community, was using a State based recruiting site, and was attending job fairs in the community in an effort to recruit Registered Nurses.	F 727	4. How the facility will monitor its performance to ensure the deficient practice does not recur: The facility administrator and/or DON will complete a summary of audit results and present them at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting, to ensure continued compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		4/24/24

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F 732	Continued From page 3 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately document the Daily Nursing Hours postings for 2 of 45 Daily Nursing Hours reports reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 1, 2024 (October 1-December 31, 2023) revealed the facility had no Registered Nurse (RN) coverage on 10/08/23, 11/19/23, 12/03/23 and 12/31/23. Review of the facility Daily Nursing Hours postings revealed on 10/08/23 and on 12/03/23 the facility counted 8 RN hours for both dates. Review of the daily assignment sheets revealed there was no RN coverage in the building on	F 732	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were named in this alleged deficient practice. The Administrator and scheduling coordinator reviewed and corrected staff postings from 10/8/23 and 12/3/23. 2. How the facility will identify other residents potentially affected by the same deficient practice: Any resident can be affected. An audit was completed by regional clinical nurse of staff postings compared with the staff schedules for the previous 30 days to ensure staff postings were accurate. Any discrepancies identified were corrected by	

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F 732	Continued From page 4 10/08/23 and 12/03/23 as posted. In an interview with the Payroll/Human Resources Coordinator on 3/20/24 at 1:00 PM she stated that no RN was scheduled or paid on 10/08/23 or 12/03/23 showing there had been no RN in the building on those dates. In an interview with the Administrator on 03/20/24 at 3:30 PM he stated he did not know why the staff postings were wrong. He noted on one of the days an RN had been scheduled but did not show up for work. He stated he verified with the Payroll Coordinator that no RN worked on10/08/23 and 12/03/23 but hours were documented on the staff postings.	F 732	the regional clinical nurse on 3/20/24. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. A daily labor meeting will be held by the Administrator, DON and scheduler and/or unit manager to review staff postings and changes to the census and schedule. This meeting will be held daily 5 days /week Monday through Friday. Education was completed for the administrator, DON, Scheduler, and Unit Managers on updating the staff postings by the regional consultant on 4/10/24 4. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administration, DON, and scheduler will be reviewing the facility schedule and staff posting to ensure they are accurate. This will be completed daily at the facility during stand down meeting. The facility administrator and/or DON will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	
F 760 SS=E	Residents are Free of Significant Med Errors	F 760		4/24/24

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F 760	Continued From page 5 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the physician order and provide sliding scale insulin to 2 residents (Resident #60 and Resident #2) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in Resident #60 not receiving a total of 21 doses of sliding scale insulin from 03/08/24 through 03/17/24 and Resident #2 not receiving a total of 6 doses of sliding scale insulin from 03/01/24-03/17/24. This was for 2 of 2 residents reviewed for insulin administration. There was no significant outcome to either resident. Findings included: 1. Resident #60 was readmitted to the facility on 2/28/24 with diagnosis including diabetes with diabetic polyneuropathy. Review of Resident #60's care plan revealed a 2/28/24 focus of at risk for hypo or hyperglycemia due to diabetes. The goal indicated Resident #60 would not exhibit signs of hypo or hyperglycemia. Interventions indicated to administer medications as ordered and observe for signs and symptoms of hypo or hyperglycemia (sweating, tremor pallor, nervousness, headache, double vision, confusion, lack of coordination, and refer to MD. A physician order dated 02/28/24 revealed Resident #60 received Januvia, an oral	F 760	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The insulin orders for Resident #60 and Resident #2 were clarified with the resident's attending physician on 3/21/24 by the unit manager. Residents #60 and #2 are receiving their insulin as ordered. 2. How the facility will identify other residents potentially affected by the same deficient practice. Insulin orders for all residents were reviewed on 3/21/24 by the unit managers. There were no other repeat/additional orders found. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The DON and Unit managers will review the last 24 hours of physician orders daily Monday through Friday in the clinical meeting to assess for accurate entry of orders. Any discrepancy will be corrected at that time. All licensed nurses were educated by the unit managers on discontinuing an old order prior to entering the new order on	

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F 760	Continued From page 6 medication used to lower blood sugar levels, 100 milligrams (mg.) once daily for hyperglycemia, elevated blood sugar levels. A 02/28/24 physician order also indicated Resident #60 received glyburide 5mg. twice daily for diabetes. The 3/2/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #60 was cognitively intact with no behaviors and received insulin. A progress note dated 3/4/24 documented by the Nurse Practitioner (NP) revealed Resident #60 was examined due to a chief complaint of diabetes. The NP noted Resident #60's blood glucose readings were elevated, likely due to a steroid taper. The plan indicated the NP would order more aggressive sliding scale insulin coverage and continue glyburide and Januvia as ordered. A physician order dated 3/8/24 indicated Novolog Flex pen 100 units per milliliter subcutaneous PRN (as needed) using facility sliding scale protocol for blood glucose 0-60=0 units insulin and call the physician, 61-350=0 units, 351-400=4 units, greater than 400 =8 units and recheck in 4 hours and if remains greater than 400 notify the physician. The order further indicated Accu-Chek blood sugar test with sliding scale. Use Novolog insulin for blood sugar greater than 200. 201-250=2 units, 251-300 =4 units, 301-350=6 units, 351-400=8 units, greater than 400=10 units for diabetes. The March 2024 Medication Administration Record (MAR) for Resident #60 indicated blood glucose readings were recorded at 6:00 AM, 11:30 AM, 4:30 PM and 9:00 PM.	F 760	4/16/24. Licensed nurses will not be able to work after 4/19/24, if they have not received this education from the unit managers. Any newly hired licensed nurses will receive this education prior to assignment. 4. How the facility will monitor its performance to ensure the deficient practice does not recur. The Director of Nursing and/or unit manager will monitor the last 24 hours of provider orders 5 days a week for 4 weeks, 3 days a week for 4 weeks, then 1 day week for 4 weeks to ensure all residents are receiving medications as ordered by the physician or nurse practitioner. The DON will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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Review of the March 2024 MAR for Resident #60 revealed the sliding scale insulin was not administered as needed for blood glucose greater than 200 mg/dl for the following:

03/0924 at 11:30 AM blood glucose reading was 248 no insulin administered
03/09/24 at 4:30 PM blood glucose reading was 265 no insulin administered
03/09/24 at 9:00 PM blood glucose reading was 327 no insulin administered
03/10/24 at 6:00 AM blood glucose reading was 209 no insulin administered
03/10/24 at 11:30 AM blood glucose reading was 247 no insulin administered
03/10/24 at 4:30 PM blood glucose reading was 247 no insulin administered
03/10/24 at 9:00 PM blood glucose reading was 301 no insulin administered
03/11/24 at 11:30 AM blood glucose reading was 238 no insulin administered
03/11/24 at 4:30 PM blood glucose reading was 210 no insulin administered
03/11/24 at 9:00 PM blood glucose reading was 231 no insulin administered
03/12/24 at 6:00 Am blood glucose reading was 202 no insulin administered
03/12/24 at 11:30 AM blood glucose reading was 268 no insulin administered
03/12/24 at 4:30 PM blood glucose reading was 287 no insulin administered
03/12/24 at 9:00 PM blood glucose reading was 313 no insulin administered
03/13/24 at 4:30 PM blood glucose reading was 305 no insulin administered
03/13/24 at 9:00 PM blood glucose reading was 215 no insulin administered
03/14/24 at 4:30 PM blood glucose reading was

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258 no insulin administered
03/14/24 at 9:00 PM blood glucose reading was 228 no insulin administered
03/15/24 at 11:30 AM blood glucose reading was 205 no insulin administered
03/15/24 at 4:30 PM blood glucose reading was 255 no insulin administered
03/15/24 at 9:00 PM blood glucose reading was 309 no insulin administered

An interview was conducted on 3/21/24 at 9:15 AM with Unit Manager #1. Unit Manager #1 stated she had routinely provided care for Resident #60 and checked her blood sugar as scheduled. She stated she was not aware of the more specific sliding scale order that was added but if she had she would have administered it as ordered. Unit Manager #1 stated the order entered in Resident #60's electronic medical record on 3/8/24 was confusing and required clarification. Unit Manager #1 reviewed the MAR and stated Resident #60 had not received the sliding scale insulin according to the physician order. The Unit Manager stated the order for Novolog Flexpen as needed for blood sugar greater than 350 is the standard protocol and should have been discontinued when the other order for sliding scale insulin was received on 3/8/24. She indicated this was likely the cause of the new more specific sliding scale order not being followed.

An interview was conducted on 3/21/24 at 9:25 AM with the Nurse Practitioner (NP). The NP stated on 3/4/24 she reviewed Resident #60's blood glucose readings and observed elevations in the readings likely caused by a steroid taper. The NP revealed on 3/8/24 she changed the

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sliding scale to provide increased coverage. The NP stated Resident #60 should have received the more aggressive sliding scale insulin coverage. The NP reviewed the MAR and indicated the facility failed to discontinue the standard protocol when the new sliding scale was entered. The NP stated the transcription error resulted in the omission of doses of sliding scale insulin according to the new order. The NP stated she expected the standard protocol for sliding scale to be discontinued when the new order was written. The NP stated Resident #60 did not experience serious outcome from the omission however it was a significant error with the potential for adverse effects.

An interview was conducted with the Director of Nursing (DON) on 3/21/24 at 9:35 AM. The DON stated Resident #60's sliding scale insulin coverage order was confusing and was entered incorrectly. The DON stated the new sliding scale order that was received on 3/8/24 should have superseded the previous order. The DON stated her expectation was for staff to follow the physician orders and indicated the sliding scale insulin was an order that should have been transcribed correctly and followed. The DON stated it was an error that the insulin was not administered per the current sliding scale order and the standard protocol should have been discontinued.

An interview was conducted with Unit Manager #2 on 3/21/24 at 10:06 AM. Unit Manager #2 stated she frequently entered physician orders in the electronic medical record, and she routinely provided care for Resident #60. Unit Manager #2 indicated the orders for sliding scale for Resident # 60 were confusing. When the NP gave the

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order for the more specific sliding scale, the prior standard as needed sliding scale protocol should have been discontinued but that was not how it was entered.

2.Resident #2 was admitted to the facility on 10/9/23 with diagnoses including diabetes mellitus.

A physician order dated 1/15/24 indicated blood sugar checks for diabetes use facility protocol sliding scale as needed.

Resident #2's 1/16/24 quarterly MDS assessment indicated resident was cognitively intact, received an injection once in the look back period and did not receive insulin or have changes to insulin orders.

A care plan dated 1/31/24 indicated a focus of diabetes with a goal of blood sugars will stabilize. Interventions included: Observe for signs of hypo and hyperglycemia and obtain blood sugars as ordered.

A physician order dated 2/21/24 indicated Novolog Flex pen injection solution 100 unit per milliliter. Inject subcutaneously every 4 hours as needed. Accu-Chek with sliding scale. Use Novolog Insulin. Inject per sliding scale for diabetes for blood glucose readings as follows 201-250=2U, 251-300=4U, 301-350=6U, 351-400=8U, BS>400 OR <70 CALL MD

Review of the March 2024 MAR for Resident #2 revealed blood glucose readings were recorded at 06:00 AM and 4:30 PM. The sliding scale insulin was not administered as needed for blood glucose readings greater than 200 mg/dl on the

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following dates:

03/04/24 at 6:00 AM blood glucose reading was 237 no insulin administered
03/05/24 at 6:00 AM blood glucose reading was 239 no insulin administered
03/08/24 at 6:00 AM blood glucose reading was 233 no insulin administered
03/09/24 at 6:00 AM blood glucose reading was 225 no insulin administered
03/11/24 at 4:30 PM blood glucose reading was 202 no insulin administered
03/16/24 at 6:00 AM blood glucose reading was 203 no insulin administered.

An interview was conducted with Unit Manager #1 on 3/21/24 at 1:15 PM. Unit Manager #1 revealed she routinely provided care to Resident #2 and entered physician orders. Unit Manager #1 indicated Resident #2 had a sliding scale insulin order as needed every four hours to be administered according to the blood glucose reading. The blood glucose readings were obtained twice per day and the order indicated to use the facility protocol which required insulin administration for a blood glucose reading of 351 or greater however the other sliding scale order indicated to administer insulin starting with a reading above 201. Unit Manager #1 stated the MAR was confusing and it was human error that doses of insulin were omitted.

An interview was conducted with the Director of Nursing on 3/21/24 at 1:20 PM. The DON revealed the omission of the insulin according to the sliding scale was a medication error. The DON stated the order was confusing and required clarification in the electronic medical record. The DON stated she expected orders to be

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F 760	Continued From page 12 transcribed correctly and medication to be administered per physician order. An interview was conducted with Unit Manager #2 on 3/21/24 at 1:45 PM. Unit Manager #2 indicated she frequently entered physician orders in the computer and routinely provided care for Resident #2. Unit Manager #2 stated Resident #2's MAR was confusing, and it was human error that the order was not entered correctly. She indicated what should have occurred when the order for the Novolog sliding scale was entered it should have been entered with the order for the blood glucose checks and that was not how it was entered. She indicated this was likely the cause of the sliding scale insulin order not being followed. An interview was conducted with the Nurse Practitioner (NP) on 3/21/24 at 3:20 PM. The NP indicated she expected the orders to be followed as ordered and expected the orders to be entered in the computer accurately and correctly. The NP stated it was imperative for the medications to be administered as ordered, especially insulin, for the evaluation of the resident and their medical condition. The NP stated Resident #2 did not experience a negative outcome due to the omission of the sliding scale insulin doses. An interview was conducted with the Administrator on 3/21/24 at 3:45 PM. The Administrator stated he expected that physician orders would be transcribed and followed accurately and correctly.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/24/24

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F 812	Continued From page 13 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure refrigerated meat items stored for use in the walk-in refrigerator for resident sandwiches were dated and sealed. This practice had the potential to affect food quality. The findings include: An observation on 03/18/24 at 12:00 PM of the kitchen's walk-in refrigerator, with the Dietary Manager (DM) revealed; two clear plastic bags of sliced sandwich ham (16 & 8 once), not sealed or dated and were open to air. The DM was unable to explain why food stored in the kitchen's walk-in refrigerator was not dated and open to air. During an interview with the DM on 03/18/24 at 12:30 PM she said she monitored the items in the	F 812	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were named in this deficient practice, The dietary manager discarded the undated ham on 3/18/2024. 2. How the facility will identify other residents potentially affected by the same deficient practice. Any resident has the potential to be affected. The dietary manager and assistant dietary manager completed observation rounds on 3/18/24 to ensure no other opened and undated items were in the cooler or freezer.	

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F 812	Continued From page 14 refrigerators and freezers weekly when conducting inventory. She stated the two bags of sliced ham should have been dated and sealed and not opened to air. During an interview with the Administrator on 03/21/24 at 2:45 PM, he reported it was his expectation the facility's kitchen staff follow all regulatory guidelines for food and kitchen sanitation safety.	F 812	3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The dietary manager or assistant dietary manager will visually inspect the kitchen freezer and cooler for opened, undated items twice daily, 5 days /week Monday through Friday. Education was completed for dietary manager regarding proper labeling of opened food by Nutrition Plus Senior Culinary Quality Assurance. This education was completed on 3/19/24. Dietary manager or Assistant Dietary Manger will audit all open food items in the kitchen freezer and cooler for proper labeling twice daily 5 days a week for 4 weeks, twice daily 3 days a week for 4 weeks, then twice daily 1 day week for 4 weeks 4. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		4/24/24

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 16 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document the time and date in the electronic Medication Administration Record (eMAR) 5 out of 28 times when prescribed as needed narcotic pain medications were removed from the narcotic dispensing cards for 2 of 2 residents reviewed (Residents #46 and #177). Findings included: A. Review of the physician orders for Resident #46 included the following order: Percocet 10 mg-325 mg tablet: Administer 1 tablet by mouth every 24 hours as needed for pain (Oxycodone	F 842	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents# 46 and 177 are receiving pain medication as needed and it is documented on the narcotic count sheet and Medication Administration records. 2. How the facility will identify other residents potentially affected by the same deficient practice. An audit comparing the declining narcotic	

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F 842	Continued From page 17 HCL/Acetaminophen). Start date 02/07/24. Review of the Controlled Drug Receipt/Record/Disposition Form for Resident #46 revealed Nurse #1 had removed one dose of Percocet 10-325 mg from the locked narcotic drawer on 03/19/24 at 6:49 PM. Review of the electronic Medication Administration Record (eMAR) for Resident #46 did not document that Oxycodone-APAP 10-325 had been administered to the resident on 03/19/24 at 6:49 PM. In an interview with Nurse #1 on 03/21/24 at 2:18 PM via phone she stated she had given Resident #46 Percocet 10-325 mg on 03/19/24 but had forgotten to sign it off in the eMAR because she had been on another hall passing medications and when she returned to this hall, she was immediately asked to medicate two residents for pain. She explained because the residents were in rooms near each other she pulled the medications for both residents at the same time and forgot to sign them out in the eMARs. B. Review of the physician orders for Resident #177 included the following order: Hydrocodone 10 mg-acetaminophen 325 mg tablet: administer 1 tablet orally every 8 hours as needed. Record the residents pain level (0-10), for pain level 1-6. Start date 03/15/24. Review of the Controlled Drug Receipt/Record/Disposition Form for Resident #177 documented Nurse #5 had removed one dose of Hydrocodone 10 mg-Acetaminophen 325 mg from the locked narcotic drawer on 03/19/24 at 9:00 AM and Nurse #1 had removed 3 doses	F 842	count sheet to the medication administration record was completed by the DON and unit managers on all residents who had orders for as needed medications. This audit was completed on 3/21/24. There were no other discrepancies found. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Education was completed by the DON for all licensed nursing staff on safely and accurately delivering medication to include signing the MAR and the narcotic count sheet when administering PRN (as needed) medications. This education was completed on 3/25/24. 4. How the facility will monitor its performance to ensure the deficient practice does not recur. Unit managers will audit declining narcotic count sheets and electronic medical records for administration of narcotics and the signing of both. This audit will be performed on 5 records, 5 times a week for 2 weeks. 5 records per day 3 days per week for 2 weeks, then 5 records weekly day for 8 weeks. The DON will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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from the drawer at on 03/19/24 at 6:49 PM and 10:00 PM and again on 03/20/24 at 6:30 AM.

Review of the electronic Medication Administration Record (eMAR) for Resident #177 did not document that Hydrocodone 10 mg-Acetaminophen 325 mg had been administered to the resident on 03/19/24 at 9:00 AM, 6:49 PM or 10:00 PM or on 03/20/24 at 6:30 AM.

An interview was conducted with Nurse #1 on 03/21/24 at 2:18 PM via phone. She stated that she had administered the pain medications to Resident #177 on 03/19/24 at 6:49 PM, 10:00 PM and again on 03/20/24 at 6:30 AM. She explained she signed the medication out of the locked narcotic drawer each time she gave the medication to him but was unable to sign off the medication in the eMAR as administered because the medication on the eMAR was locked. She stated she did not know how to unlock a medication in the eMAR and since the Director of Nursing had changed, she did not know who had the authority to unlock it.

An interview was conducted with Nurse #5 on 03/27/24 at 5:39 PM via phone. She stated she recalled Resident #177 and was positive she had administered Hydrocodone to him on 03/19/24 at 9:00 AM because it was the only time she had given him any pain medication. She explained she signed the medication out of the locked narcotic drawer but had forgotten to document it on the eMAR.

In an interview with Unit Manager #1 on 3/21/24 at 2:50 PM she stated she expected all medications to be documented accurately on the

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F 842	Continued From page 19 narcotic reconciliation sheet and in the eMAR. She stated if a nurse marked a medication in the eMAR as "prepared" but did not return to mark it as "administered", the medication would lock, and no further documentation could be added until the nurse who originally marked it as "prepared" returned and documented that dose as "administered." She was not sure which staff member could unlock a medication in an eMar since the last DON had left but noted that she could not. In an interview with the Administrator on 3/21/24 @ 4:19 PM he stated he expected the nurses to document in the narcotic record and the eMAR each time a medication was administered.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		4/24/24

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information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness

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of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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F 867	Continued From page 22 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner interview and staff interviews, the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification survey completed on 10/26/21 and an on-site revisit survey and complaint investigation survey completed on 02/04/23. This was for three repeat deficiencies originally cited in the areas of Posted Nurse Staffing Information (F732), Residents Are Free of Significant Med Errors (F760) and Resident Records - Identifiable Information (F842). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross-referenced to: F732: Based on record review and staff interviews, the facility failed to accurately document the Daily Nursing Hours postings for 2 of 45 Daily Nursing Hours reports reviewed.	F 867	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The insulin orders for Resident #60 and Resident #2 were clarified with the resident's attending physician on 3/21/24 by the unit manager. Residents #60 and #2 are receiving their insulin as ordered. Residents# 46 and 177 are receiving pain medication as needed and it is documented on the narcotic count sheet and Medication Administration records. 2. How the facility will identify other residents potentially affected by the same deficient practice. Any resident had the potential to be affected by this deficient practice. At the facility monthly QAPI meeting held 4/16/24, the committee reviewed the current statement of deficiencies for	

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F 867	Continued From page 23 During the recertification survey of 10/26/21 the facility failed to post accurate nurse staffing information. F760: Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the physician order and provide sliding scale insulin to 2 residents (Resident #60 and Resident #2) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in Resident #60 not receiving a total of 21 doses of sliding scale insulin from 03/08/24 through 03/17/24 and Resident #2 not receiving a total of 6 doses of sliding scale insulin from 03/01/24-03/17/24. This was for 2 of 2 residents reviewed for insulin administration. There was no significant outcome to either resident. During the recertification survey of 10/26/21 the facility failed to prevent significant medication errors by 1) not following the physicians order to increase Zoloft (used in treatment of major depressive disorder) from 50 mgs (milligrams) to 75 mgs daily resulting in failure to administer 41 doses of Zoloft 75mgs and 2) not following the physicians order to hold 10 units of Novolog insulin 100 units/ml (milliliter) for blood glucose less than 300 mg/dl (deciliters) resulting in 4 doses of Novolog insulin 10 units administered when blood glucose was less than 300 mg/dl for 3 of 24 residents whose Medication Administration Record (MAR) was reviewed. F842: Based on record review and staff interviews, the facility failed to accurately document the time and date in the electronic Medication Administration Record (eMAR) 5 out of 28 times when prescribed scheduled and as	F 867	survey ending March 27,2024. This review included a review of our recent repeat tags, F 732, F 760, and F 842. It was decided that these repeat deficiencies will be reviewed weekly by the facility QAPI committee to ensure ongoing compliance. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. All department managers, including Social Work, Director of Nursing, Activities Director, Housekeeping Manager, Maintenance Director, Admissions Director, Medical records coordinator, Rehab Director, MDS (Minimum Data Set) nurses, Human Resources, and Central Supply received education on 4/16/24 by the regional clinical nurse on F867 and the facility QAPI program. Any new facility department manager will receive this training during their orientation by the facility Administrator and/or Director of Nursing 4. How the facility will monitor its performance to ensure the deficient practice does not recur. The Regional Director of Operations and/or Regional Clinical Nurse will review Quality Assurance Process Improvement (QAPI) minutes monthly for 3 months, then quarterly for three quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 24	F 867		

needed narcotic pain medications were removed from the narcotic dispensing cards for 2 of 2 residents reviewed (Residents #46 and #177).

During the recertification survey of 10/26/21 the facility failed to accurately document the administration of a medication, Clonazepam 0.25 milligrams (mg), on the Medication Administration Record (MAR).

During the on-site revisit and complaint investigation survey of 02/04/23 the facility failed to maintain an accurate medical record that included an unwitnessed fall.

In an interview with the facility Administrator on 03/21/24 at 4:19 PM he stated he was not sure why deficiencies had repeated. He felt staff turnover had contributed. He did note he had failed to monitor the daily staff posting to ensure accuracy and planned to review the posting daily going forward.