STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 04/25/2024

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THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 04/09/24 to conduct a complaint investigation survey and exited on 04/11/24. Additional information was obtained on 04/12/24 and 04/25/24. Therefore, the exit date was changed to 04/25/24. The following intakes were investigated NC00215433 and NC00215433. Two (2) of the 2 complaint allegations did not result in deficiency. Event ID# UXFI11.	F 000		
F 580 SS=D	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 physician.	F 580		5/18/24

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

Electronically Signed | 05/15/2024

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F 580	Continued From page 1 (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 interviews with the Medical Doctor and staff the facility failed to notify the physician of a change in the resident's level of consciousness that resulted in delay in the treatment of a possible opioid overdose for 1 of 1 resident reviewed for notification (Resident #1). Findings included: Resident #1 was admitted to the facility on 4/15/23 with diagnoses including chronic obstructive pulmonary disease (COPD), heart failure, and anxiety disorder. The quarterly Minimum Data Set dated 2/1/24	F 580	F580 Notify of Changes (Injury/Decline/Room, etc.) Resident #1 is no longer a resident at the facility. All residents are at risk for the deficient practice. By May 15, 2024, the Director of Nursing or Designee will complete a record review of residents transferred to hospital in previous 30 days. The audit will include a comparison of the date and time of change of condition first noted and date and time physician notification to ensure	

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F 580	Continued From page 2 assessed Resident #1's cognition was severely impaired. Review of neuro checks documented by Nurse #1 on 3/31/24 revealed at 7:00 AM Resident #1's level of consciousness (LOC) was alert and her eyes opened to speech and verbal responses were oriented. At 8:30 AM her LOC was drowsy, and her eyes opened to speech, but the verbal responses were now confused. From 9:30 AM through 12:30 PM Resident #1 was asleep with no other information provided on those neuro checks. The next neuro check at 4:30 PM revealed Resident #1's LOC remained drowsy, but her eyes now opened to pain, and verbal responses continued as confused conversation. Further review of Resident #1's medical record revealed there was no documentation that the physician was notified of the resident's change in level of consciousness from 9:30 AM through 4:30 PM. During an interview on 4/9/24 at 1:14 PM Nurse #1 revealed on 3/31/24 she was responsible for the care and completed the neuro checks for Resident #1 who appeared sleepy with each one. It was sometime after lunch when Nurse Aide (NA) #1 made her aware Resident #1 did not eat and was still sleeping. She stated Resident #1's vital signs were normal and when she tried to wake the resident her eyes did open but she would go right back to sleep. She asked Nurse #2 sometime after lunch to check Resident #1 as she was not very familiar with the resident. Resident #1 was transferred to her wheelchair and placed at the nurse station so the nursing staff could keep an eye on her. Nurse #1 stated when Resident #1's LOC did not change, she	F 580	that timely notification to physician occurred and there were no delays in treatment as a result of a lack of notification. No additional issues were notes. On or before May 15, Director of Nursing or Designee will educate all licensed nurses to notify physician immediately upon change in resident condition. Education included that altered level of consciousness or a significant change/deterioration in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications should be recognized as a change in condition where physician notification should occur promptly. Newly hired licensed nurses and those contracted through agencies will be educated upon hire and prior to accepting a resident assignment. The Director of Nursing or designee will audit the 24-hour report in morning clinical meeting for a completion in change of condition assessment and validate proper physician notification time and date 5 x week for 8 weeks. The report review each Monday will include the previous 72 hours to ensure review of weekend days. The results of the audits will be brought to the monthly Quality Assurance Process Improvement Committee for review and recommendations will be made as the committee determines. The Administrator is responsible for implementation of the plan of correction.	

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F 580	Continued From page 3	F 580	Date of compliance is 5/18/24.	

reported it to Unit Manager #2 right before emergency medical services (EMS) was called (5:47 PM) and Resident #1 was transferred to hospital.

An interview was conducted on 4/10/24 at 2:15 PM with Nurse #2. Nurse #2 stated on 3/31/24 sometime after lunch Nurse #1 asked her to check Resident #1 because the resident was sleepy. Nurse #2 stated it was not Resident #1's baseline to be sleepy after lunchtime, but Nurse #1 said the vital signs were normal. Nurse #2 stated that she, and NA #1 transferred Resident #1 to the wheelchair, and she took the resident to Unit Manager #2 and asked her to watch Resident #1 because she was sleepy. Nurse #2 revealed Resident #1 does have times she was sleepy but on 3/31/24 kept closing her eyes and would not stay awake when talking with her.

Review of Unit Manager #2's progress note dated 3/31/24 at 6:22 PM revealed Resident #1's was assessed for a change of condition due to altered mental status and appeared very sleepy and continued to be lethargic till supper time. Unit Manager #2 notified the Medical Doctor who recommended Resident #1 be sent to the emergency room for further evaluation.

An interview was conducted with Unit Manager #2 on 4/11/24 at 12:16 PM. Unit Manager #2 revealed she saw Resident #1 sitting in the wheelchair at the nurses' station on 3/31/24 sometime after lunch and it appeared she was taking a nap and resting. She stated no one ask she check Resident #1 for decreased LOC at that time. She revealed it was sometime after 5:00 PM when Nurse #1 reported Resident #1 was "very sleepy." She assessed Resident #1 who

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F 580	Continued From page 4	F 580		

appeared sleepy and called the MD and received an order to send Resident #1 to the emergency room.

Review of the EMS report revealed on 3/31/24 at 5:47 PM EMS was called and on the scene at 5:57 PM. The EMS narrative revealed nursing home staff reported Resident #1 had not spoken since 12:30 PM and appeared extremely lethargic. EMS assessed Resident #1 was alert to verbal stimuli, aphasic (loss of speech) with constricted pupils.

During an interview on 4/16/24 at 5:32 PM the Director of Nursing (DON) stated it appeared Nurse #2 did not emphasize or provide enough information to Unit Manager #2 about what was going on with Resident #1. The DON stated the nurses monitored Resident #1 neurological checks and noted there were no abnormal vital signs and no difficulty with breathing and based their decision not to call the MD on that information. She stated the nurses should have notified the MD for further guidance when Resident #1 was first noted to have a decreased LOC and not wait as long as they did.

An interview on 4/12/24 at 3:26 PM the MD stated when Resident #1 presented with changes in her LOC observed by the nurses, he would expect the nurse to notify the MD right away to determine if resident needed to be sent to the hospital and "the sooner the better." He stated he did not know what condition Resident #1 was in when she arrived at the hospital or what her vital signs were and cannot say the delay in treatment caused Resident #1 harm.

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F 609	Continued From page 5	F 609		
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 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 and interviews with the Police Detective and staff the facility failed to submit an initial report to the state agency no later than 2 hours after receiving an allegation of neglect that resulted in hospitalization for a suspected opioid overdose for a resident who	F 609	F 609 Reporting of Alleged Violations Resident # 1 is no longer a resident at the facility.	5/18/24

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F 609	Continued From page 6 was not prescribed opioids. This deficient practice was for 1 of 3 residents reviewed for abuse (Resident #1). Findings included: Resident #1 was admitted to the facility on 4/15/23. The discharge Minimum Data Set dated 3/31/24 indicated Resident #1 was discharged to the hospital and expected to return to the facility. The resident was not taking opioid medications during the lookback period. Review of the hospital records revealed on 3/31/24 Resident #1 was admitted for drowsiness, altered mentation, and appeared disoriented and weak. A urine drug screen revealed Resident #1 was positive for opiates and the hospital suspected an overdose and administered two doses of naloxone (an opioid reversal agent-opioid antagonist). Review of the facility's initial investigation to the state agency revealed the date and time the facility became aware of the neglect allegation was 4/3/24 at 11:45 AM. During an interview on 4/11/24 at 11:30 AM the Police Detective stated he contacted the facility on 4/2/24 and served a subpoena to obtain the medical records of Resident #1. The Police Detective revealed an allegation of neglect was made against the facility related to a medication. The Police Detective revealed he was in a hurry and did not speak with the Administrator on 4/2/24 and gave the subpoena to the person at the front desk and left.	F 609	All residents who allege a state reportable incident are at risk for the deficient practice. On 5/10/24, an audit of state reportable incidents over the last 30 days was completed by the administrator to ensure that no other examples of a delay in reporting occurred. There were no additional issues were identified. Facility Administrator was in-serviced by Regional Director of Operations on May 10, 2024, on ensuring that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made. If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, reporting should occur no later than 24 hours after the allegation is made. Facility Administrator will audit state reportable incidents for proper notification timeframe per regulation monthly for 2 months. The results of the audits will be brought to the monthly Quality Assurance Process Improvement Committee for review and recommendations will be made as the committee determines. The administrator is responsible for the implementation of the plan of correction. Date of compliance is 5/18/24.	

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F 609	Continued From page 7 An interview was conducted on 4/11/24 at 5:11 PM with the Administrator. The Administrator revealed it was sometime after 4:30 PM on 4/2/24 when she was notified the facility was served subpoena requesting the medical records of Resident #1. She explained the subpoena included the reason was for either potential or possible negligence. She no longer had the subpoena for review but stated she was told a second Police Detective would be back in morning on 4/3/24 to explain the details. On 4/3/24 at approximately 11:45 AM the Police Detective reported the family alleged neglect related to a medication and at that time she called the Department of Social Services and sent the initial report to the state agency and began the investigation. The Administrator revealed she was aware Resident #1 was treated at the hospital for suspected opiate overdose and was not currently prescribed any type of opioid medication and she considered that as a possible medication error not a report of abuse or neglect.	F 609		
F 684 SS=G	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 and interviews with the	F 684	F684 Quality of Care	5/18/24

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F 684	Continued From page 8 Medical Doctor, Family Member, and staff the facility failed to initiate medical services for treatment of an acute change in the level of consciousness (LOC) when a resident (Resident #1) appeared lethargic and difficult to arouse. Neurological checks showed Resident #1 was drowsy at 8:30 AM with confused conversation and remained at the facility until emergency medical services was called at 5:47 PM resulting in a delay of treatment. Resident #1 was admitted to the hospital 3/31/2024 secondary to drowsiness and altered mentation. She remained in the hospital from 3/31/24 through 4/10/24 and received treatment for acute metabolic encephalopathy, acute on chronic hypoxemic respiratory failure with hypoxia, possible aspiration pneumonia, and pulmonary hypertension. This was for 1 of 3 residents reviewed to ensure the facility was free of medication errors. Findings included: Resident #1 was admitted to the facility on 4/15/23 with diagnoses including chronic obstructive pulmonary disease (COPD), heart failure, and anxiety disorder. The quarterly Minimum Data Set dated 2/1/24 assessed Resident #1's cognition was severely impaired, and she was not taking opioid medications during the lookback period. The care plan last revised on 2/25/24 identified the risk of acute or chronic pain related to peripheral vascular disease, neuropathy, and falls. Interventions included administer analgesia per Medical Doctor (MD) orders and monitor for side effects of pain medication and report to the	F 684	Resident #1 is no longer a resident at the facility. All residents with a change in condition are at risk for the deficient practice. The Director of Nursing or Designee will complete by, May 15, 2024, a record review of residents with a change in condition in previous 30 days to ensure proper medical care for treatment of an acute condition was initiated. Beginning on 5/10/24, Director of Nursing or Designee educated all licensed nurses to identify a change in condition and immediately begin interventions. Education included that altered level of consciousness or a significant change/deterioration in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications should be recognized as a change in condition where physician notification should occur. Nurses will implement an intervention for each acute change in condition as soon as the change in condition is noted. Interventions are to include completion of an e-Interact Change in Condition form, notification of change to physician and responsible party, and prompt follow-up when receiving new orders or provider recommendations. Newly hired licensed nurses and those contracted through agencies will be educated upon hire and prior to accepting a resident assignment. The Director of Nursing or designee will	

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F 684	Continued From page 9 nurse complaints of pain or request for treatment. Review of the physician orders revealed no opioid medications were prescribed for Resident #1 while she was a resident at the facility. Review of the Medication Administration Record (MAR) for Resident #1 revealed the nurses initialed the following medications were administered on 3/31/24: -Levothyroxine 125 micrograms (mcg) for hypothyroidism (decreased thyroid hormones) at 6:30 AM. -Lidocaine 4% external patch for pain at 8:00 AM. -Diltiazem 240 milligrams (mg) for cardiovascular at 8:00 AM. -Pregabalin 75 mg for anxiety at 8:00 AM. -Torsemide 10 mg for edema (accumulation of fluid in body tissue) at 8:00 AM. -Albuterol sulfate 2.5 mg/3 milliliter nebulization treatment for wheezing at 8:00 AM. -Diclofenac Sodium gel 1% for neck pain at 8:00 AM. -Acetaminophen extra strength 1000 mg for pain at 8:00 AM. -Saline nasal gel for nosebleed at 9:00 AM. -Fluticasone-Umeclidin-valiant 200-62.5-25 mcg for COPD at 9:00 AM. -Clonazepam 0.5 mg for anxiety at 9:00 AM (drug class benzodiazepine not identified as positive on the hospital urine drug screen on 3/31/24). Review of a nurse progress note dated 3/31/24 at 4:59 AM revealed Unit Manager #1 documented the situation-background-assessment-recommendation (SBAR) to evaluate Resident #1 for fall on 3/30/24. Unit Manager #1 documented no changes were observed in Resident #1's mental	F 684	audit 24-hour report in morning clinical meeting for a completion in change of condition interventions 5 x a week for 8 weeks to ensure appropriate and timely interventions were completed. The report review each Monday will include the previous 72 hours to ensure review of weekend days. The results of the audits will be brought to the monthly Quality Assurance Process Improvement Committee for review and recommendations will be made as the committee determines. The administrator is responsible for implementation of the plan of correction. Date of compliance is 5/18/24.	

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F 684	Continued From page 10	F 684		

status.

During an interview on 4/11/24 at 9:47 AM Unit Manager #1 revealed right before she documented the SBAR on 3/31/24 at 4:59 AM she checked Resident #1 who was asleep in the recliner chair wearing a bilevel positive airway pressure (BiPap) (a non-invasive ventilation machine that helps with breathing and sleep apnea) and was not in distress. Unit Manager #1 explained the SBAR was a scheduled assessment for a follow-up from a previous fall on 3/30/24 used to identify any type of latent injury or change of condition and routine protocol after a resident fell. Unit Manager #1 revealed she did not administer any medications or take vital signs when she did the SBAR evaluation.

Review of Resident #1's neuro checks that included vital signs and documented by Nurse #1 on 3/31/24 revealed the following:
- 7:00 AM blood pressure 96/58, pulse 80, respiratory rate 18, and temperature 98.1 and the LOC alert, eyes opened to speech, and verbal responses were oriented.
- 7:30 AM blood pressure 107/63, pulse 78, respiratory rate 17, temperature 97.5, LOC was drowsy, eyes opened to speech, and verbal responses were oriented.
- 8:00 AM blood pressure 113/75, pulse 85, respiratory rate 18, temperature 97.3, LOC was drowsy, eyes opened to speech, and verbal responses were oriented.
- 8:30 AM blood pressure 110/81, pulse 72, respiratory rate 17, temperature 97.5, LOC drowsy, eyes opened to speech, and verbal responses were now confused.
- 9:30 AM Nurse #1 documented asleep with no other information provided.

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F 684	Continued From page 11	F 684		

- 10:30 AM Nurse #1 documented asleep with no other information provided.
- 11:30 AM Nurse #1 documented asleep with no other information provided.
- 12:30 PM Nurse #1 documented asleep with no other information provided.

Review of Resident #1's electronic medical record labeled "vital signs" revealed on 3/31/24 at 10:18 AM the resident's blood pressure was 96/58 and at 11:40 AM the blood glucose was 123 and oxygen level was 94% and was documented by Nurse #1.

The next neuro check recorded by Nurse #1 on 3/31/23 at 4:30 PM included vital signs with a blood pressure reading of 132/85, pulse 73, respirations 16, and temperature 97.3. Nurse #1 documented Resident #1's LOC remained drowsy, eyes now opened to pain, and verbal responses continued as confused conversation.

Review of the progress note written on 3/31/24 at 6:31 PM by Nurse #1 read in part, "Resident #1 took the morning medications, had eaten small amount of breakfast, was sitting in the chair, and was sleepy. Resident #1 did not eat lunch, was lethargic, could not speak loudly but could follow some commands. The vital signs and blood sugar were taken, and Resident #1 was sent to the hospital."

During an interview on 4/9/24 at 1:14 PM Nurse #1 revealed on 3/31/24 she was responsible for the care and completed the neuro checks for Resident #1 who appeared sleepy with each one. During the morning medication pass Nurse #1 stated she had to wake Resident #1 who was sleeping in the recliner chair, and they had short a

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conversation and made eye contact and the resident said she was sleepy. She described during their conversation Resident #1 did not slur her speech and it appeared she was just sleepy. It was sometime after lunch when Nurse Aide (NA) #1 made her aware Resident #1 did not eat and was still sleeping. She stated Resident #1's vital signs were normal and when she tried to wake the resident her eyes did open but she would go right back to sleep. She asked Nurse #2 sometime after lunch to check Resident #1 as she was not very familiar with the resident. Nurse #2 checked Resident #1's vital signs and they were normal, and Resident #1 was transferred to her wheelchair and placed at the nurse station so the nursing staff could keep an eye on her. Nurse #1 stated when Resident #1's LOC did not change, she reported it to Unit Manager #2 right before emergency medical services (EMS) was called and Resident #1 was transferred to hospital. Nurse #1 confirmed she did not administer the scheduled dose of clonazepam at 2:00 PM to Resident #1 because she was sleeping.

An interview was conducted with the NA #1 on 4/10/24 at 3:19 PM. NA #1 revealed he was responsible for assisting Resident #1 with care on 3/30/24 and 3/31/24 and it was the first time he was the assigned NA for the resident and he was not very familiar with her. On 3/30/24 NA #1 stated he observed Resident #1 was active and doing everything herself and used the walker to take herself to the bathroom. On 3/31/24 NA #1 revealed his shift started at 7:00 AM and Resident #1 was awake and when he picked up the breakfast tray Resident #1 had not eaten or drank what was served. He asked Resident #1 if she needed help with eating and she shook her

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head to indicate no but did not say anything. After breakfast NA #1 stated he observed Resident #1 in the recliner chair with the television on and it was after lunch when he reported to Nurse #1, she did not eat breakfast or lunch. Nurse #1 took vital signs and asked another nurse to check Resident #1 and a second set of vital signs were taken. After the vital signs were taken NA #1 stated he assisted with transferring Resident #1 to the wheelchair, and she was placed at the nurse station for the nurses to watch.

An interview was conducted on 4/10/24 at 2:15 PM with Nurse #2. Nurse #2 stated on 3/31/24 sometime after lunch Nurse #1 asked her to check Resident #1 because the resident was sleepy. Nurse #2 stated Resident #1 was sleeping in the recliner chair and when she called her name her eyes opened, and she looked at the nurse and said her son and daughters' names then closed her eyes and went back to sleep. Nurse #2 stated that was not Resident #1's baseline to be sleepy after lunchtime, but Nurse #1 said the vital signs were normal. Nurse #2 stated she, and NA #1 transferred Resident #1 to the wheelchair, and she took the resident to Unit Manager #2. She asked Unit Manager #2 to watch Resident #1 because she was sleepy. Nurse #2 stated normally Resident #1 was a one person assist with transfer, but that day needed two persons. Nurse #2 revealed Resident #1 does have times she was sleepy but on 3/31/24 kept closing her eyes and would not stay awake when talking with her.

Review of the nurse's progress dated 3/31/24 at 6:22 PM revealed Unit Manager #2 documented an SBAR evaluation that included Resident #1's vital signs at 5:45 PM and the blood pressure was

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153/54, pulse 75, respiratory rate 18 breaths per minute, blood glucose 121, oxygen level 91%, and temperature 98.1. The SBAR was an evaluation of Resident #1 for a change of condition due to altered mental status. The note read in part, "appeared very sleepy after lunch, refused to eat lunch, and continued to be lethargic till supper time. Was easy to arouse using verbal and tactile stimuli. Complained of shortness of breath and received a bronchodilator inhaled medication but was slow to respond. The physician was notified and recommended to send Resident #1 to the emergency room for further evaluation."

An interview was conducted with Unit Manager #2 on 4/11/24 at 12:16 PM. Unit Manager #2 revealed she saw Resident #1 sitting in the wheelchair at the nurses' station on 3/31/24 sometime after lunch and it appeared she was taking a nap and resting and stated no one communicated Resident #1 had been lethargic with decrease LOC or asked her to monitor or check Resident #1 at that time. She revealed it was sometime after 5:00 PM when Nurse #1 told her Resident #1 was very sleepy and asked her to check Resident #1. Unit Manager #2 stated she went directly to the room of Resident #1 and the resident's vital signs and a blood sugar had already been taken and none were abnormal. She described her assessment of Resident #1 who answered questions correctly using clear speech and followed commands and to her Resident #1 appeared sleepy with a low voice tone and was difficult to hear. Unit Manager #2 stated she called the MD right after her assessment and received an order to send Resident #1 to the emergency room. Unit Manager #2 revealed on 3/31/24 she was the

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person the nurses report to, and no one reported they had administered the wrong medication. She revealed she had worked on 3/30/24 from 7:00 AM through 7:00 PM and Resident #1 was visiting with a family member, and they were talking and eating and there were no concerns.

Review of the EMS report revealed on 3/31/24 at 5:47 PM EMS was called and on the scene at 5:57 PM. The EMS narrative revealed nursing home staff reported Resident #1 had not spoken since 12:30 PM and appeared extremely lethargic. The EMS neurological assessment indicated Resident #1 was alert to verbal stimuli, aphasic (loss of speech) with constricted pupils and an intravenous catheter for saline fluids was placed.

Review of the hospital records revealed on 3/31/24 Resident #1's evalution described she was slightly hypertensive, disoriented and weak but moving all extremities and nontoxic appearing. The Physician noted Resident #1 was well known to hospitalist service and had a complex medical history including chronic respiratory failure on home oxygen, chronic diastolic congestive heart failure, chronic kidney disease and diabetes mellitus with long-term insulin use. She had a thorough evaluation in the emergency department (ED) for altered mental status including head CT which was normal. Vitals signs in the ED included: BP 160/70, Pulse 87, Temperature 98.1 °F and Respirations 20. Resident #1 was admitted for drowsiness and altered mentation. The urine drug screen was positive for opiates and negative for benzodiazepines. It was noted in the hospital records Resident #1 was administered Clonazepam (benzodiazepine) earlier that day.

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Resident #1 was positive for opiates with no documented administration of opioid medication in the resident's MAR. The hospital suspected an overdose and administered naloxone (an opioid reversal agent-opioid antagonist) and Resident #1 did awaken for a few minutes and then dozed off again. She was given a second dose of naloxone and had severe vomiting. Resident #1 was treated with antibiotics from 4/1/24 through 4/4/24 for possible aspiration pneumonia. A swallow study was obtained on 4/4/24 for concern of aspiration and identified minimal aspiration was present and recommended thickened liquids. Mild respiratory depression was noted with a rate of 10 breaths per minute and Resident #1 required 6 liters of oxygen before weaned back to a baseline oxygen use of 3 liters. Creatinine (lab used to check kidney function) was high 2.06 (normal 0.5 - 0.8) and the sodium level was high 146 (normal 136- 145) and Resident #1 was treated with intravenous fluids for acute kidney failure with history of stage 3 kidney disease. A chest x-ray on 4/4/24 identified congestion and edema related to a history of pulmonary hypertension that was treated with furosemide (a medication used to remove excess fluid from the body). Resident #1 remained in the hospital until discharged in stable condition on 4/10/24.

An interview was conducted with the Family Member who visited Resident #1 on 3/30/24. The Family Member revealed he came to facility around 4:00 PM and visited with Resident #1 for approximately 1 to 2 hours and she did not appear sleepy and did not doze off and they had a normal conversation with each other. The Family Member revealed on 3/31/24 sometime between 5:00 PM or 6:00 PM he received a message Resident #1 was sent to the hospital

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and when he first saw her, she was mumbling non-legible words and it appeared to him she was in a coma like state. He was told the hospital found some type of opioid in her system and observed them administer naloxone and after the first dose was given Resident #1 woke up right away and started talking and forming legible words. That lasted approximately 2 to 3 minutes then Resident #1's condition went back to the same as it was. She was given a second dose of naloxone and had projectile vomiting and was in the hospital from 3/31/24 through 4/10/24.

During an interview on 4/16/24 at 5:32 PM the Director of Nursing (DON) stated based on her interviews with the nurses and NA staff Resident #1 ate a little bit of breakfast and took her morning medications and it was sometime around lunch time when Nurse #2 indicated she had informed Unit Manager #2 that Resident #1 appeared to have decreased LOC. It was shared with the DON that Unit Manager #2 stated she did not receive report about Resident #1 until sometime after 5:00 PM. The DON stated it appeared Nurse #2 did not emphasize or provide enough information to Unit Manager #2 about what was going on with Resident #1's decreased LOC nor did she ask her to assess the resident. The DON stated the nurses monitored Resident #1 and did the neurological checks and it was noted there were no abnormal vital signs and no difficulty with breathing and the nurses based their decision not to call the MD on that information. The DON stated the nurses were aware Resident #1 did not always wear her BiPap at night and would appear sleepy the next day. She stated the nurses should have notified the MD for further guidance when Resident #1 was first noted to have a decreased LOC and not wait

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as long as they did. The DON was aware Resident #1 received 2 doses of naloxone at the hospital for a suspected opioid overdose and revealed the facility had naloxone available for use when a resident was suspected to have an opioid overdose, but no one suspected that as the cause of lethargy or decreased LOC because Resident #1 had no physician's orders for any type of opioid medication. The DON stated the nurses were educated to notify the MD right away when a resident had a change of condition or decreased LOC due to there were many unknown factors including a possible medication error that could cause a resident to have a change of condition or decrease in LOC.

An interview was conducted on 4/9/245 at 9:45 AM with the MD. The MD revealed he was surprised the hospital's urine drug screen was positive for opiates since Resident #1 did not have an order for any type of opioid medication and this was why the facility requested a second test to rule out false positive. He did not understand why the drug screen was negative for the clonazepam that was ordered to be administered daily and was given on 3/30/24 and 3/31/24. He stated clonazepam remained in the body's system for at least 24 hours after being taken and he would have expected it to be identified in the urine drug screen on 3/31/24. The MD stated he had no other information about how the Resident #1's urine drug screen was positive for opiates but understood why the hospital suspected the resident received the wrong medication. The MD described Resident #1's baseline if having a good day, she was able to communicate her medical needs and have a conversation with him.

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F 684	Continued From page 19 During a follow-up interview on 4/12/24 at 3:26 PM the MD stated when Resident #1 presented with changes in her LOC observed by the nurses, he would expect the nurse to notify the MD right away to determine if resident needed to be sent to the hospital and "the sooner the better." The MD stated he did not know what condition Resident #1 was in when she arrived at the hospital or what her vital signs were and cannot say the delay in treatment caused Resident #1 harm. The MD stated he was aware Resident #1 was lethargic and the urine tested positive for opiates and two doses of naloxone were administered for suspected opioid overdose. During an interview on 4/22/24 at 8:28 AM the Police Detective revealed the blood and urine samples law enforcement obtained from Resident #1 while in the hospital to rule out the possibility of a false positive or contaminated sample were sent to the state lab, but no results had been received at this time. The Police Detective revealed he would notify the State Agency (surveyor) as soon as possible once those results were received.	F 684		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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	F 726		5/18/24

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F 726	Continued From page 20 accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to verify or check the competency and skills of an agency nurse prior to providing care and services to residents for 1 of 2 staff reviewed for competency (Nurse #3). Findings included: Review of the employee file for Nurse #3 revealed the facility verified an active and unencumbered license to practice in the state. The file did not contain verification that skills or competencies were checked to ensure Nurse #3 was competent to provide care and services to residents prior to her assignment on 3/30/24. During an interview on 4/10/24 at 3:54 PM Nurse	F 726	F 726 Competent Nursing Staff Nurse #3 is no longer contracted to work at the facility. By May 15, 2024, the Director or Nursing or designee will audit all currently scheduled licensed staff for competency and skills verification for ability to provide care and services to residents. A skills/competency verification will be completed on any nurse who is found to be out of compliance by the Director of Nursing or designee. All residents are at risk of the deficient practice. On 5/10/24, the administrator educated the Human Resource Director, the Director of Nursing, Assistant Director	

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F 726	Continued From page 21 #3 confirmed she worked for a nurse staffing agency. Nurse #3 revealed on 3/30/24 she worked the night shift from 6:45 PM through 7:15 AM on 3/31/24 and it was her first shift at the facility. An interview was conducted on 4/11/24 at 5:11 PM with the Director of Nursing (DON) and Administrator. The DON stated the facility used several staffing agencies but the competencies skills for Nurse #3 was not verified by the facility prior to her assignment on 3/30/24. She explained it was an emergency, a holiday, and last-minute attempt to cover the shift. The DON stated the Unit Manager and Administrator were at the facility during the shift on 3/30/24 and available to assist and answer any questions Nurse #3 needed help with. The Administrator revealed the facility recently lost the Scheduler whose task included setting up employee files for every agency staff in a facility position. This was the process used in the past the facility had implemented in which the Scheduler would set up agency staff files to include skill competencies check off, but the facility had lost several Schedulers. The Administrator stated moving forward the newly hired Scheduler would be tasked with setting up employee records for agency staff, but their training was not completed. The Administrator revealed it was in their contract with the staffing agencies that prior to sending staff to the facility their skills were checked to ensure they were competent to provide care and services to residents. The Administrator confirmed they did not verify with the staffing agency they had checked the competency and skills of Nurse #3 before she worked the shift on 3/30/24 and stated the agency kept the skills competency check off.	F 726	of Nursing and the scheduler that all newly hired or agency nursing staff must have verification of skills/competency presented upon booking or completed on or before the first shift worked in the facility. The verification of skills/competency will be completed by the Director of Nursing or designee. The Assistant Director of Nursing or the Human Resource Manager will verify that a skills/competency verification is present for all newly hired or agency nursing staff on or before the first shift worked in the facility. The verifications of skills/competency will be kept in a binder in the Assistant Director of Nursing's office. The Director of Nursing or designee will audit 5 nursing staff records for verification of competencies and skills validation weekly for 8 weeks. The results of the audits will be brought to the monthly Quality Assurance Process Improvement Committee for review and recommendations will be made as the committee determines. The administrator is responsible for implementation of the plan of correction. Date of compliance is 5/18/23.	

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F 726	Continued From page 22 A follow-up interview with Nurse #3 was attempted on 4/12/24 at 1:52 PM with no response.	F 726		