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F 000	INITIAL COMMENTS	F 000		

A complaint investigation survey was conducted from 04/22/24 through 04/24/24. Immediate jeopardy was identified for F689 example #2. On 5/6/24 the survey team returned to the facility to validate the immediate jeopardy removal plan for F689 example #2, and investigate new complaints that were received since leaving the facility on 4/24/24. The survey team identified immediate jeopardy at F580 and F684. The survey team investigated through 05/10/24. During state agency quality review, additional immediate jeopardy deficiencies were identified: F600, F726, example #1 for F689. The survey team returned to the facility on 05/22/24 to validate the credible allegations of immediate jeopardy removal for F580, F684, F600, F726 and example #1 for F689. Therefore, the exit date was changed to 05/22/24. Event ID# 2RGE11.

The following intakes were investigated: NC00213953, NC00215842, NC00216058, NC00216175, NC00216406, NC00216520, NC00216599, NC00216631, NC00216636, and NC00216772. Intakes NC00215842, NC0021663 and NC00216636 resulted in immediate jeopardy. 11 of the 21 complaint allegations resulted in deficiency.

Immediate Jeopardy was identified at:

CFR 483.10 at tag F580 at a scope and severity (J);
immediate jeopardy began on 03/02/24 and was removed on 05/17/24

CFR 483.12 at tag F600 at a scope and severity

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/08/2024

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 000	Continued From page 1 (J); immediate jeopardy began on 03/02/24 and was removed on 05/17/24 CFR 483.25 at tag F684 at a scope and severity (J); immediate jeopardy began on 03/02/24 and was removed on 05/17/24 CFR 483.25 at tag F689 at a scope and severity (K); for example #1 immediate jeopardy began on 03/01/24 and was removed on 05/18/24 for example #2 immediate jeopardy began on 02/20/24 and was removed on 04/30/24 CFR 483.35 at tag F726 at a scope and severity (J); immediate jeopardy began on 03/02/24 and was removed on 05/17/24 The tags F600, F684, and F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;	F 563		7/1/24

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F 563 Continued From page 2

(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;
(iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and
(v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.
This REQUIREMENT is not met as evidenced by:
Based on observation, record reviews, an audio digital file, and interviews from resident, staff, and visitor, the facility failed to allow unrestricted visitation by limiting visitation for 1 of 1 resident reviewed for visitation (Resident #3).

The findings included:

Resident #3 was re-admitted to the facility on 11/24/23.

An admission Minimum Data Set (MDS) assessment dated 11/30/23 indicated Resident #3's preferences included the following: It was very important to have family, or a close friend, involved in discussion about care.

Review of Resident #3's quarterly MDS dated

F 563

F563

Immediate action taken to resolve this alleged deficiency:

A meeting was requested with the Responsible Party for Resident #3 on 5-24-2024 and again on 6-4-2024 to discuss a review of visitation arrangements for the former Social Worker. The Administrator contacted the resident's daughter to discuss the visitation rights of Resident #3 and the former Social Worker. Education was provided to all staff on 5-24-24 and 6-10-2024 on resident's rights to include the process in allowing resident visitation. Additional inservices on Resident Rights

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2/7/24 indicated Resident #3 had severe cognitive impairment and required extensive assistance for most activities of daily living (ADL).

An observation and interview with Resident #3 and Visitor #1 on 5/6/24 at 9:25 AM revealed Visitor #1 stated that Resident #3 became upset and expressed emotions through tears when she was notified that Social Worker #1 would not be able to visit any longer. Visitor #1 stated Resident #3 always looked forward to and enjoyed visits from Social Worker #1 when she visited after business hours or on weekends. Visitor #1 stated it would be Resident #3's wishes to have Social Worker #1 visit her.

A telephone interview with Social Worker #1 on 4/30/24 at 10:57 AM revealed she was no longer employed at the facility but was the former Social Worker and had self-terminated her employment after approximately 25 years of service in the facility. Social Worker #1 stated she resigned from her employment around 4/5/24 and had continued to visit Resident #3 once to twice weekly during the month of April 2024. Social Worker #1 said she received a voicemail from the Administrator on 4/29/24 which indicated she would no longer be "extended the luxury" to visit and be on the facility premises because she was a self-terminated employee and that this notification would be "followed up by a legal notice."

A review of the voicemail left on 4/30/24 (time unknown) on Social Worker #1's telephone by the facility Administrator revealed the following audible message: "Hey [Social Worker #1] this is [Administrator] calling from [facility name]. Just wanted to touch base with you and let you know

F 563

have been scheduled for 6-12,6-13,-6-14,and 6-15-2024 by the Consulting Nurse and Social Work Director. The Administrator was reeducated by the Clinical Consultant on 5-31-2024 A review of the resident roster on 6-4-2024 demonstrated customized visitation arrangements for three, (3) residents in which accommodations were customized to accommodate the individual residents.

The facility acknowledges that all residents have the potential to be affected by this alleged deficiency.

Measures put into place to ensure that this does not recur: Resident Rights obligations policy and procedure is included in the employee handbook as an employee reference to the facility's visitation policy.

Additional information provides the actions necessary should a visit become upsetting to the resident or other facility residents so that modifications can be made when necessary.

Monitoring will be completed by the staff recording any expressed concern over any visitors in the event the visit is upsetting to the resident/or residents. Residents preferences for points of contact for visitors will be reviewed during the Clinical Interdisciplinary Team Discussion In addition, should a resident's visitor be restricted either legally or for protection purposed the facility will

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F 563	Continued From page 4 as far as visiting or being on the facility premises, we are not going to be able to extend that luxury to you. So, if you have any questions at all about what our policy is about self-termed employees are, please give me a call. We will be following this up with a legal notice to you in regard to this. If you have any questions, don't hesitate to give me a call. Alright, thank you. Bye. Bye." An interview with the Administrator on 5/7/24 at 9:45 AM revealed she had denied visitation to Resident #3. The Administrator stated she had left Social Worker #1 a voicemail regarding her being a self-terminated employee and her not being able to visit any longer because she felt it was best not to allow Social Worker #1 to return to the premises because if she allowed Social Worker #1 to visit then she would have to allow all other self-terminated employees to visit as well which she did not want to do at the time. The Administrator confirmed she had not spoken to Social Worker #1 since the voicemail had been left and stated she had written up a letter regarding Social Worker #1 not being allowed to visit and submitted it to the owner who had chosen for it not to be mailed to Social Worker #1. The Administrator said she had received no further updates regarding the visitation of Social Worker #1 to any resident in the facility from the owner.	F 563	follow the direction given. The Administrator will review all grievances for any expressed visiting complaint. A report will be presented to the Quality Assurance and Process Improvement Committee for 12 weeks. Completion date: 7-1-2024	
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-	F 580		7/1/24

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(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.
(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

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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 reviews, and interviews with resident, staff and the Medical Director, the facility failed to notify a medical provider of significant changes in a resident's condition (Resident #8) who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 suspected drug overdose and administered one dose of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on 3/2/24 at 9:34 AM and an additional dose at 9:54 AM without notifying a medical provider. Resident #8 responded temporarily to the Narcan doses but at 3:50 PM, he was observed with no heart rate or respiratory rate and was pronounced dead. In addition, the facility failed to notify the Guardian after a resident (Resident #6) tested positive for tetrahydrocannabinol (THC - a compound found in cannabis/marijuana plants). This deficient practice affected 2 of 3 residents reviewed for notification of changes (Resident #8).

Immediate jeopardy began on 3/2/24 when the facility failed to notify a medical provider of significant changes in Resident #8's condition suggestive of a possible drug overdose. The immediate jeopardy was removed on 5/17/24 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual

F 580

F580 Notification of Changes

The immediate action taken to address this alleged deficient practice includes the following:

1.The facility notified the medical provider of the suspected drug overdose of resident #8 who was observed unresponsive to painful stimuli, low oxygen saturation, and pupil constriction receiving 2-doses of Narcan on 3/2/24 at 9:34am and 9:54am on 5/10/24 by the Director of Nursing Services (DNS) A Facility wide audit completed to determine if any resident who received Narcan the medical provider has been notified by Nurse Consultant by 5/10/24. The audit identified 3-residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician order.

2. Resident #6 was assessed by Nurse #2 on 4-6-2024 upon observation of change of condition. Nurse #2 immediately notified the On Call Physician to notify them of the behavior of Resident # 6. The Guardian for Resident #6 was notified by The Director of Nursing. The Social Work

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harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.
Example #2 is out of compliance at a level of D.

The findings included:

1. Resident #8 was admitted to the facility on 12/20/22.

A progress note dated 3/2/24 at 9:36 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 was given Narcan per order. Oxygen saturation 68% (normal value 95% or higher), resident not responding to painful stimuli, pupils constricted. Narcan given in each nostril. Resident now 95% on oxygen. Blood pressure 128/72 (normal value less than 120/80), heart rate 84 (normal value 60 to 100 beats per minute), respirations 18 (normal value 12 to 18 breaths per minute) and regular.

Another progress note dated 3/2/24 at 9:47 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 now resting with eyes closed. Oxygen saturation 98%. No signs/symptoms of pain or shortness of breath.

A phone interview with Nurse #14 on 5/8/24 at 10:56 AM revealed she was working as the weekend supervisor on 3/2/24 when Agency Nurse #20 alerted her. Nurse #20 told her that she had no idea what to do about Resident #8. When Nurse #14 came into Resident #8's room, he was very sweaty and was not responding. Resident #8 was sitting in his wheelchair at his bedside, and he was slumped over. Nurse #14 stated that she was afraid Resident #8 might fall

F 580

Director created an updated list of all residents denoting their legally appointed guardian and ensuring contact numbers were current and available to the clinical staff for notification purposes.

The facility recognizes that all residents that have a Narcan order have the potential to be affected by this alleged deficient practice.

Measures put into place to ensure that this alleged deficient practice does not recur includes includes the following:

A facility look-back audit of 30-days was completed to ensure any resident that was administered Narcan, the medical provider was notified, completed by Nurse Consultant on 5/10/24. The audit did not identify any other residents who were administered Narcan. An audit will be completed by 5/12/24 by the Nurse Consultant on the number of residents who use opioids, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids. The audit identified 3-residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician order.

" Re-education to licensed nursing staff, including agency nurses on ensuring

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forward off his wheelchair, so Nurse Aide (NA) #20 helped her put him back in bed. Nurse #14 stated that she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications he took by himself. Nurse #14 further stated after she gave Resident #8 the two doses of Narcan, he perked up. Nurse #14 said she thought Nurse #20 spoke with the on-call provider while she was busy taking care of Resident #8. Nurse #14 also stated that she did not think to call 911 because it seemed like the two doses of Narcan worked, and she noted on the physician's order that she could give another dose after 10 minutes if the first one did not work. After Nurse #14 administered the second dose, she observed that Resident #8's oxygen saturation was within normal limits, and he was talking to her although he said that he was tired and just wanted to lay there in the bed. Nurse #14 stated that Nurse #20 told her that she had called the doctor, and she thought that Nurse #20 had also called 911. Nurse #14 stated that she knew this was Nurse #20's first day working at the facility.

A progress note dated 3/2/24 at 10:00 AM by Nurse #20 in Resident #8's medical record indicated: Resident #8 was sitting up in wheelchair, very difficult to arouse. Oxygen saturation was 71% on oxygen via nasal cannula. Resident #8 was placed back to bed with head of bed elevated. Somewhat more responsive but continued to nod off. Oxygen saturation increased to the low 80% with deep breaths. Narcan administered by Nurse #14. Narcan somewhat effective, more alert and verbal. Morning medications held.

F 580

the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders by the Director of Nursing Services/Assistant Director of Nursing (designee) by 5/11/24. Licensed nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed.

" Facility wide audit completed to determine if any resident who received Narcan the medical provider has been notified by Nurse Consultant by 5/10/24. The audit identified 3-residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician

The Director of Nursing or Designee will notify the medical provider of the administration of Narcan by the DNS reviewing the 24-hour report on a daily basis for appropriate notification documentation in the Electronic Medical Record (EMR). Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the Director of Nursing Services and/or the Assistant Director of Nursing Services, Unit Managers, and Supervisors.
If the Director of Nursing Services is unavailable the Assistant Director of Nursing will assume this responsibility of reviewing the 24-hour report.

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A second progress note dated 3/2/24 at 12:58 PM by Nurse #20 in Resident #8's medical record indicated: Resident #8 difficult to arouse at this time. Responds to sternal rub (application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) with mumbles. Oxygen on per order via nasal cannula. BiPAP (bilevel positive airway pressure which is a form of non-invasive ventilation therapy used to help you breathe) placed on. More verbal and alert at this time.

A third progress note dated 3/2/24 at 3:50 PM by Nurse #20 in Resident #8's medical record indicated: Upon observation, no heart rate or respiratory rate noted. Responsible party aware. Nurse Practitioner aware, order to release body to the funeral home received and noted. Funeral home contacted per family request.

A phone interview with Nurse #20 on 5/8/24 at 12:26 PM revealed NA #21 alerted her that Resident #8 was lethargic. When Nurse #20 checked Resident #8's oxygen saturation, it was dropping so she asked Nurse #14 for help. Resident #8 woke up somewhat after he received the two doses of Narcan. Nurse #20 explained that 3/2/24 was her very first day working at the facility as an agency nurse and she did not have access at the time to the clinical messaging platform that the facility used to contact the on-call providers. Nurse #20 stated that she did not think about calling the on-call provider because she thought that Nurse #14 took over Resident #8's care when she gave him the Narcan. Nurse #20 explained that during this incident, she was still trying to get her medication pass done, and she thought Nurse #14 was going

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Monitoring will be completed by the Director of Nursing reviewing the results of the ongoing Audit and observing patterns and trends of residents that receive written Narcan orders. The results from the 24 hour report and the medical record review will reflected in the monthly report. Results from this report will be presented to the monthly Quality Assurance Committee For 3 months.

Completion Date: 7-1-2024

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to take care of Resident #8. Nurse #14 stated she did not recall telling Nurse #14 whether she called the provider or not because she thought Nurse #20 was going to do it.

A phone interview with the former Social Worker (SW) on 5/8/24 at 12:45 PM revealed she was the manager on duty on 3/2/24. The former SW stated that when she came in that morning around 9:30 AM, Nurse #14 told her that Resident #8's pupils were pinpoint, and that they needed help to put him back into bed. The former SW stated she observed Resident #8 slumped over in his wheelchair and she thought he was going to die right there. Resident #8's eyes were pinpoint, and she watched Nurse #14 give Resident #8 two doses of Narcan. The former SW further stated that she told Nurse #14 that the facility's policy was to immediately call EMS, call the doctor and send the resident to the hospital after the resident was given Narcan. The former SW stated that she told Nurse #14 to call EMS right after Nurse #14 administered the Narcan to Resident #8.

A joint interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/8/24 at 1:11 PM. The ADON stated that she did not know if Nurse #14 notified the provider, but said she would have called the doctor if she was at the facility.

An interview with the Medical Director (MD) on 5/8/24 at 10:21 AM revealed he last saw Resident #8 on 3/1/24 when he visited him after he had just gotten back from the hospital for COPD and CHF, and he seemed to be doing fine during the visit. The MD stated that he was not notified when Resident #8 died but he found out about it the next day he visited the facility. The MD stated that

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he did not know that they administered Narcan to Resident #8, and he was not familiar with the facility policy for Narcan. The MD stated that if the policy indicated for staff to notify EMS when administering Narcan, then they should have followed that. The MD confirmed that low oxygen saturation and pupil constriction were signs of overdose, and that Resident #8 should have been sent out to the hospital on 3/2/24. The MD added that if an on-call provider was notified about the Narcan doses, then there would be a note in Resident #8's chart and they would have ordered to send him out to the hospital.

The Administrator was notified of immediate jeopardy on 5/10/24 at 2:50 PM.

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:
The facility failed to notify the medical provider of the suspected drug overdose of Resident #8 who was observed unresponsive to painful stimuli, had low oxygen saturation, and pupil constriction, and received 2 doses of Narcan on 3/2/24 at 9:34 AM and 9:54 AM.

The guidelines for notifying physicians of clinical problems to ensure 1) medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record was not followed in the administration to Resident #8 by Nurse #14.

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The facility notified the medical provider of the suspected drug overdose of Resident #8 who was observed unresponsive to painful stimuli, low oxygen saturation, and pupil constriction receiving 2 doses of Narcan on 3/2/24 at 9:34 AM and 9:54 AM on 5/10/24 by the Director of Nursing Services (DNS).

A facility look-back audit of 30 days was completed by the Nurse Consultant on 5/10/24 to ensure that for any resident that was administered Narcan, the medical provider was notified. The audit did not identify any other residents who were administered Narcan. An audit will be completed by 5/12/24 by the Nurse Consultant on the number of residents who use opioids, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids. The audit identified 3 residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician order.

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.

The specific actions the facility will take to alter the system failure to prevent a serious outcome from reoccurring are:

* Re-education to licensed nursing staff, including agency nurses on ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders by the Director of Nursing Services/Assistant Director of Nursing (designee)

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by 5/11/24. Licensed nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed.

* Facility wide audit completed by Nurse Consultant by 5/10/24 to determine if for any resident who received Narcan, the medical provider has been notified. The audit identified 3 residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician order.

* The actions the facility will take to ensure the nurses notify the medical provider of administration of Narcan by the DNS reviewing the 24-hour report on a daily basis for appropriate notification documentation in the Electronic Medical Record (EMR). Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the Director of Nursing Services and/or the Assistant Director of Nursing Services, Unit Managers, and Supervisors.

* If the Director of Nursing Services is unavailable the Assistant Director of Nursing will assume this responsibility of reviewing the 24-hour report.

* Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose prior to working their first shift by the DNS/Assistant Director of Nursing (designee).
The alleged date of immediate jeopardy removal

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is 5/17/24.

The credible allegation for the immediate jeopardy removal was validated on 5/22/24 with a removal date of 5/17/24.

A review of in-service education records dated 5/11/24 indicated education was provided to nurses including agency nurses on ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with the nursing staff including agency nurses revealed they had been educated on notifying the medical provider of any resident who receives Narcan for suspected overdose.

The audit completed by the Nurse Consultant on 5/10/24 was reviewed. All residents identified as having orders for Narcan administration had notification of medical providers added to the Narcan order.

The facility's date of immediate jeopardy removal of 5/17/24 was validated.

2. Resident #6 was admitted to the facility on 11/15/19.

The nurse's progress notes dated 04/06/24 revealed Resident #6 was found to have slurred speech and unable to sit, stand, or keep his eyes opened at around 8:45 PM. He could not answer questions from the staff but was making the comment "I feel good and high". Around 9:00 PM, a urine specimen was obtained per the on-call provider's order for a drug screening. On 04/07/24 at 1:30 AM, the results from the urine drug screening were obtained and faxed to the

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on-call provider.

A review of medical records indicated Resident #6 had a 12-Panel urine drug screening conducted on 04/06/24 and was positive for THC.

A review of medication administration records (MARs) from 01/01/24 through 04/23/24 revealed Resident #6 was not ordered to receive any medications containing THC.

During an interview conducted on 04/23/24 at 3:30 PM, Resident #6 stated he would not take drugs from anyone except nurses in the facility. He attributed the incident to the medications he received from the nurses in the facility prior to the incident.

A phone interview was conducted with Nurse #2 on 04/23/24 at 4:15 PM. She stated she worked second shift from 7 PM to 7 AM on 04/06/24 evening and was providing care for Resident #6 in 300 Hall. At around 8:45 PM, Resident #6 was brought to her by a staff member from the rehab department with altered mental status, impaired movements, and slurred speech. She contacted the on-call provider immediately and was told to monitor Resident #6's vital signs and collect urine specimen for a drug screening. After obtaining Resident #6's urine specimen, she ordered one of her nurse aides (NA) to bring it to the local hospital immediately and waited for the results. At around 1:30 AM, the results from the urine drug screening confirmed Resident #6 was positive for THC. She faxed the results to the on-call provider immediately and was ordered to report the results to the Director of Nursing (DON). She did not notify Resident #6's Guardian after she received the drug screening results as it was late and

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non-urgent. She explained after she notified DON and Unit Manager (UM) #2 in the morning, she assumed either one of them would notify the Guardian.

During an interview conducted on 04/24/24 at 10:30 AM, Resident #6's Guardian stated he did not know that Resident #6 was tested positive for THC on 04/07/24 morning and confirmed none of the staff in the facility had notified him about the drug screening results after the incident. It was his expectation for the facility to notify him within 24 hours after the incident occurred.

During an interview conducted on 04/24/24 at 11:52 AM, UM #2 stated Nurse #2 reported the incident to her on 04/07/24 in the morning. However, she did not specifically ask her to notify Resident #6's Guardian before leaving for the shift, and she assumed the notification had been made.

An interview was conducted with the DON on 04/24/24 at 12:54 PM. She stated the hall nurse (Nurse #2) was responsible for notifying the Guardian after Resident #6 was tested positive for THC. The UM would be the back-up if the hall nurse was unable to do it. It was her expectation for the hall nurse and the UM to communicate with each other to ensure the Guardian was notified as soon as possible.

An interview was conducted with the MD on 04/24/24 at 1:53 PM. He stated he was being notified of the incident on 04/07/24 in the morning and expected the Guardian to be notified in a timely manner as well.

During an interview conducted on 04/24/24 at

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F 580	Continued From page 17 3:28 PM, the Administrator stated it was her expectation for the facility to notify Resident #6's Guardian regarding the incident in a timely manner.	F 580		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance 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;	F 584		7/1/24

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F 584	Continued From page 18 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain clean and sanitary floors (bathroom of room 214, 208, 301 rooms 310, 301, 303, 211), maintain clean and sanitary privacy curtains (rooms 206 and 211), ensure a baseboard was clean and sanitary (room 208), ensure the toilet was clean and in good repair (room 212), ensure a bathroom was free of lingering odors (room 212), and maintain baseboards in good repair (bathroom of 303 and 114) for 3 of 4 halls (100 hall, 200 hall, and 300 hall) reviewed for safe, clean, and homelike environment. The findings included: 1. (a). An observation of the shared bathroom floor of room 214 on 05/07/24 at 10:35 AM revealed dried yellow and brown stains scattered across the entire floor. Additional observations of the shared bathroom floor of room 214 on 05/10/24 at 8:57 AM revealed dried yellow and brown stains scattered across the entire floor. (b). An observation of the bathroom floor of room 208 on 05/07/24 at 10:43 AM revealed multiple areas of dried brown/black stains scattered across the floor. Additional observations of the bathroom floor of room 208 on 05/08/24 at 8:58	F 584	F584 Immediate action taken to correct the alleged deficient practice Include the following: 1.(a) The shared bathroom flooring in room 214 was cleaned by the Environmental Services Director on 5-22-2024. (b) The bathroom and room floor for room 208 was cleaned to remove all stains and to clean all food debris. This was completed by the Environmental Services Director on 5-22-2024. (c) The floor in room 310 was cleaned to remove any debris observed. The Environmental Services Director completed this task on 5-22-2024. (d) The floors in 301 B were cleaned of food debris by the Environmental Services Director on 5-22-2024. e) The floor in the room 303 was cleaned also by Environmental Services on 5-22-2024.	

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AM and 05/10/24 at 8:23 AM revealed multiple areas of dried brown/black stains scattered across the floor.

(c). An observation of the floor of room 310 on 05/07/24 at 11:15 AM revealed scattered food debris across the entire floor. Additional observations of the floor of room 310 on 05/07/24 at 3:34 PM and 05/08/24 at 9:03 AM revealed scattered food debris across the entire floor.

(d). An observation of the floor of room 301-B on 05/07/24 at 11:20 AM revealed the floor was covered with food debris. An observation of the bathroom floor of room 301 at the same date and time revealed multiple areas of dried yellow/brown stains across the entire floor and a wad of brown hair was lying on the floor. Additional observations of the floor and bathroom floor of room 301 on 05/10/24 at 9:05 AM revealed the entire room floor was covered with food debris and the bathroom floor had multiple areas of dried yellow/brown stains across the entire floor and a wad of brown hair was lying on the floor.

(e). An observation of the floor of room 303 on 05/08/24 at 9:06 AM revealed scattered food debris across the entire floor.

(f). An observation of the floor of room 211 on 05/10/24 at 8:55 AM revealed food debris to the entire floor.

An interview with Housekeeper #1 on 05/10/24 at 11:50 AM revealed she worked 9:00 AM to 2:00 PM. She stated her assignment on 05/10/24 was 300 hall and 400 hall, any offices upstairs, and the therapy room. Housekeeper #1 stated

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2. Privacy Curtains for rooms 206 and 211 were changed on 5-22-24 by the Environmental Services Director.

3.Baseboards in room 208 were cleaned by the Director of Environmental Service on 5-22-2024. The baseboard was reattached to the wall by the Maintenance Director on 5-24-2024.

4.The 212 bathroom was cleaned on 5-22-2024 by the Environmental Services Department. The Maintenance Director replaced the Caulking around the base of the toilet on 6-4-2024.

5.The bathroom of room 303 had the baseboard replaced by the Maintenance Director on 5-24-2024.

The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Identification of further facility Environmental and Maintenance concerns will be identified by the department managers completing and reporting the result of assigned room round observations during the management meetings. Observations of needed repairs and requested cleaning needs will be directed to the department appointed to oversee the resolution of any

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cleaning each resident room consisted of collecting trash, sweeping and mopping the floors in the rooms and bathrooms, cleaning the sink and toilet, and cleaning baseboards if they appeared dirty. She stated there were days when she was unable to clean all of her assigned rooms before her shift ended and she notified her supervisor if she was unable to finish her assignment.

An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated routine cleaning of resident rooms included disinfecting all flat surfaces, sweeping and mopping the floor and bathroom floor, cleaning the bathroom sink, toilet, shower, and removing the trash. The Housekeeping Director stated all resident rooms were to be cleaned in the morning if possible and then a second should be performed to see if the rooms needed further attention. She stated she had been short on housekeeping staff, but she rounded on resident rooms to check for concerns and management staff also had a group of rooms they were assigned to check and notify her of any housekeeping concerns. The Housekeeping Director stated she expected bathrooms and resident rooms to be clean.

2. (a) An observation of the privacy curtain between beds in room 206 on 05/07/24 at 10:56 AM revealed a large, dried brown/purple stain approximately halfway up the curtain. Additional observations of the privacy curtain between beds in room 206 on 05/07/24 at 3:23 PM, on 05/08/24 at 8:27 AM, on 05/08/24 at 12:28 PM, and on 05/10/24 at 8:50 AM revealed a large, dried brown/purple stain approximately halfway up the curtain.

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reported problem.

Measures put into place to ensure that this alleged deficient
Practice does not recur includes the following: A review of the
Room rounding areas of concern were reviewed with the Department
Managers on 5-22-2024 during the daily stand down meeting. This review was completed by the Administrator. The Department Managers are responsible for completing room rounding and reporting any observed concerns with cleanliness or needed repairs so that immediate action can be taken to address any areas identified as needing immediate cleaning or repair. Inservices were held by the Interim Environmental Services Director on the cleaning expectations for privacy curtains, 5 and 7 step room cleaning lists and deep cleaning requirements on 6-4-2024. This education was to Deep Cleaning Schedules, and reiterate/educate as to what the daily cleaning tasks were each room assigned. Notification was also escalated to the Administrative Management of the Housekeeping/Environmental Department to request oversight of the cleaning process to insure that the tasks are meeting expectations. The Interim Environmental Director will conduct daily rounding and audit observations to ensure that the daily cleaning lists are completed. A Privacy Curtain Audit was completed on 5-16-2024 to ensure all curtains were clean. No other issues were noted as a result of this audit. A flooring and buffing

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(b). An observation of the privacy curtain closest to the door of room 211 on 05/10/24 at 8:55 AM revealed scattered dried brown stains.

An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated she changed room divider curtains monthly and were also checked by housekeeping daily. The Housekeeping Director stated she also changed room divider curtains when she was notified of any concerns, and she was not aware of any concerns with the curtains in rooms 206 and 211. She stated she expected room curtains to be clean and free of stains.

3. An observation of the baseboard of room 208-B to the left of the bed on 05/07/24 at 10:43 AM revealed a dried dark brown stain. Additional observations of the baseboard of room 208-B to the left of the bed on 05/08/24 at 8:58 AM and 05/10/24 at 8:23 AM revealed a dried dark brown stain.

An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated housekeeping staff should clean baseboards when they were visibly soiled and when rooms were deep cleaned. The Housekeeping Director stated she had been short of staff, but she had just hired a new housekeeper and was hoping that would make her available to do more deep cleaning of resident rooms.

4. An observation of the bathroom of room 212 on 05/07/24 at 10:38 AM revealed the entire area around the base of the toilet had yellow and brown stains and a strong odor of urine was

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schedule was also developed on 5-20-2024 to ensure that all floors are being deep cleaned daily as well as detailed monthly. Daily Reporting of available staffing for the Environmental Services
Department and Maintenance is reviewed during the Managers meeting. The Environmental Departments District Manager assigned to the facility will provide
Oversight to this department. This oversight will report
Completed housekeeping assignments are adequately resolved.

Monitoring will be completed by the following systems:
All department managers have been assigned room rounds.
A room rounding observation sheet has been provided to each
Department manager. This sheet contains a focus check list that
Allows monitoring of the daily observations of floors, bathrooms, Caulking, baseboards, and in room furnishings. Regional reports of Administrative oversight will be reviewed with the facility Administrator monthly.
Daily reports will be completed by the Department Managers of the observations made for Environmental Services and Maintenance so that immediate attention and correcton can be completed. Repairs observed that are needed and requested Will be entered into the electronic software program for monitoring for Any identified building repair. The

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F 584	Continued From page 22 noted. Additional observations of the bathroom of room 212 on 05/08/24 at 8:54 AM and on 05/10/24 at 8:58 AM revealed the entire area around the base of the toilet had yellow and brown stains and a strong odor of urine was noted. An interview with the Maintenance Director on 05/10/24 at 11:10 AM revealed he checked 4 to 5 random rooms each week for any maintenance issues that may need to be addressed. He stated management staff are assigned a group of rooms they check Monday through Friday and were supposed to notify him of any maintenance concerns. The Maintenance Director stated work order forms were available in a folder outside his door and could be completed and slid under his door and he also accepted verbal work order requests from staff. He stated he was not aware of any concerns with the caulking around the toilet in room 212. An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated resident bathrooms were to be cleaned daily and should be free of odors. 5. (a) An observation of the bathroom of room 303 on 05/08/24 at 9:06 AM revealed the baseboard behind the toilet was pulling away from the wall. An additional observation of the bathroom of room 303 on 05/10/24 at 10:50 AM revealed the baseboard behind the toilet was pulling away from the wall. (b). An observation of the bathroom of room 114 on 05/10/23 at 9:03 AM revealed the baseboard behind the toilet was pulling away from the wall.	F 584	Maintenance and Environmental Service Director will complete a monthly report and on any identified Areas in need of intervention. This report will be presented on a monthly For 3 months or until a pattern of compliance has been established. Completion Date: 7-1-2024	

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F 584	Continued From page 23 An interview with the Maintenance Director on 05/10/24 at 11:10 AM revealed he checked 4 to 5 random rooms each week for any maintenance issues that may need to be addressed. He stated management staff are assigned a group of rooms they check Monday through Friday and were supposed to notify him of any maintenance concerns. The Maintenance Director stated work order forms were available in a folder outside his door and could be completed and slid under his door and he also accepted verbal work order requests from staff. He stated he was not aware of any concerns with the baseboards in the bathrooms of 303 and 114. The Maintenance Director stated he expected all baseboards to be in good repair. An interview with the Administrator on 05/10/24 at 4:15 PM revealed the maintenance and housekeeping departments had corrected a number of environmental issues over the past few months and still had a number of projects they were planning to address. She stated she expected resident rooms and bathrooms to be clean and free of odor, privacy curtains to be free of stains, and baseboards to be in good repair.	F 584		
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.	F 600		7/1/24

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F 600	Continued From page 24 §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 reviews, and interviews with staff and the Medical Director, the facility failed to protect a resident's right to be free from neglect when they failed to provide care and services to a resident experiencing a medical emergency. The facility failed to activate emergency response for Resident #8 who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 administered two doses of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on 3/2/24 at 9:34 AM and 9:54 AM, with positive response, for suspicion of drug overdose. At 3:50 PM, Resident #8 was observed with no heart rate or respiratory rate and was pronounced dead. In addtion, on 1/20/24 the facility neglected to provide incontinence care to Resident #8 who was cognitively intact but experienced mental status changes with new onset of hallucination and confusion and required increased assistance with toileting. Resident #8 had a fall on 1/20/24 while attempting to go to the bathroom without assistance. Resident #8 was hospitalized with a left hip fracture requiring surgical repair and a four centimeter laceration to the left upper extremity which required two-layer suture repair. This deficient practice affected 1 of 4 residents reviewed for abuse and neglect (Resident #8). Immediate jeopardy began on 3/2/24 when staff	F 600	F600 Free from Abuse and Neglect Corrective action for the residents affected by the deficient practice includes: Education was provided to all clinical nursing staff on the expectations and situations of notifying the Medical Director, Responsible Party, Administrative nursing and the facility Administrator by the Director of Nursing. This inservice was provided on 5-11-2024. Emergency Response Drills were also completed for the direct care clinical staff by the Director of Nursing and Assistant Director of Nursing on 5-11-2024 to ensure that clinical staff could demonstrate their retention of the provided education. Preventing Abuse and Neglect Inservices were provided to all facility staff, as well as, agency staff to educate on the the policy and procedures to the different types of abuse and neglect, reporting requirements, obtaining resident and staff statements. On 5-7-2024, the Director of Nursing initiated employee questioning in regard to the incident involving Resident #8. Nursing Assistant #18 was interviewed by	

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found Resident #8 slumped over, non-responsive with constricted pupils and impaired respiration and administered two doses of Narcan for suspected drug overdose, was not provided emergency medical services, and subsequently died. Immediate jeopardy was removed on 5/17/24 when the facility implemented a credible allegation of immediate jeopardy removal. Example #2 is out of compliance at a level of G.

The findings included:

1. The first example for this tag is cross-referred to:

F580 - Based on record reviews, and interviews with resident, staff and the Medical Director, the facility failed to notify a medical provider of significant changes in a resident's condition (Resident #8) who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 suspected drug overdose and administered one dose of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on 3/2/24 at 9:34 AM and an additional dose at 9:54 AM without notifying a medical provider. Resident #8 responded temporarily to the Narcan doses but at 3:50 PM, he was observed with no heart rate or respiratory rate and was pronounced dead. In addition, the facility failed to notify the Guardian after a resident (Resident #6) tested positive for tetrahydrocannabinol (THC - a compound found in cannabis/marijuana plants). This deficient practice affected 2 of 3 residents reviewed for notification of changes.

F684 - Based on record reviews, and interviews

F 600

the Director of Nursing, Assistant Director of Nursing and Administrator needed the Abuse and Neglect Inservices were provided to all facility staff and agency staff members on 5-7-24, 5-8-24,5-9-24,5-10-24,5-11-24,5-12-24,and 5-17-24 by the Administrator, Director of Nursing and the Director of Social Work.

The facility recognizes that all resident's have the potential to be affected by this alleged Deficient practice.
A 30 day look back completed by the facility Nurse consultant did not produce or reveal any other expressed events. This was completed for the a review of any resident that had an order for Narcan administration. No other reports of Narcan being administered were discovered.

2. A facility audit will be completed by the Social Work Director and the Nurse Unit Manager by observation and interview of other the other facility residents to ensure that the residents feel their needs are being met.

Measures put into place to ensure that this alleged deficient practice does not recur includes:

A root cause analysis revealed that education was needed on reassigning resident care when exceptions dictate. Any staff assignment change would be manually handwritten on the scheduling sheet. The charge nurse for the unit will initial the change in assignment indicating that all staff involved are aware of the

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with staff and the Medical Director, the facility failed to initiate emergency medical services for symptoms of a drug overdose. Resident #8 was slumped over, non-responsive with constricted pupils and impaired respiration. Resident #8 was observed by a facility staff member with no heart rate or respiratory rate and was pronounced dead on 3/2/24 at 3:50 PM. This deficient practice affected 1 of 3 residents reviewed for quality of care.

F726 - Based on record reviews, and staff interviews, the facility failed to ensure nursing staff were trained and competent with responding to medical emergencies, activating emergency procedures with emergency medical services, and notifying medical providers for 1 of 4 residents (Resident #8) reviewed for neglect. Nursing staff failed to notify a medical provider of significant changes in a resident's condition who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction, and failed to immediately initiate emergency procedures with 911. Resident #8 expired on 3/2/24. This was for 2 of 2 staff members reviewed for competency (Nurse #20 and Nurse #14).

The Administrator was notified of immediate jeopardy on 5/11/24 at 10:37 AM.

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:

The facility neglected to activate emergency

changes in care responsibilities.

The Director of Nursing, Assistant Director of Nursing, and the Administrator met with Nursing Assistant #18 to obtain the employee statement. Education was provided as to how to manage any necessary care assignment changes with the necessary changes communicated and verified by the assigned nurse.

The facility provided education to the facility staff on Abuse, Neglect Prevention. Clinical staffing received detailed education by the Director of Nursing, and the Assistant Director of Nursing on the clinical expectations of activating an Emergency Response. This education was provided on 5-11-2024. Education was provided to all staff and agency staff on Abuse and Neglect Prevention on 5-8, 5-9, 5-10, 5-11, 5-12 and 5-17 by the Administrator and Department Managers. Daily rounds will be made by all Department Managers of facility residents to inquire of any concerns. Immediate reporting of any expressed concerns will be reported in the daily management meeting and interventions initiated by the department and Administrative staff.

The Narcan Administration Policy was reviewed by the Nursing Administrative team in conjunction with the Medical Director to provide clarification on the steps required for emergency activation upon Narcan administration. The actions the facility will take to ensure the nurses have activated the emergency response

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response for Resident #8 after Nurse #14 administered Narcan on 3/2/24 at 9:34 AMand, again at 9:54 AM with positive response for suspicion of drug overdose. In addition, the nurse supervisor did not activate emergency response.

All residents who use opioid medications are at risk of overdose and may be subject to the need for Narcan administration and emergency response. An audit will be completed by 5/12/24 by the Nurse Consultant on the number of residents who are prescribed opioid medication, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids.

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.

The specific actions the facility will take to alter the system failure to prevent a serious outcome from reoccurring are:
* The licensed nursing staff who neglected to activate emergency response were Nurse #14 and Nurse #20.

* The facility has filed a report of the neglect to the health care personnel registry on 5/13/24.

* Education on the facility policy for Abuse and Neglect Prevention was presented to all facility staff beginning 5/6/24 by the Administrator, Director of Nursing and Assistant Director of Nursing. This educational in-service included the policy and implementation of procedures to prevent abuse and neglect. Included in this education was a review of staff training

F 600

as indicated in the physician□s orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers. Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee). This education will be completed prior to any shift assignment. The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system. which is denoted in the revised Narcan Administration Policy 5/10/24.

Monitoring will be completed by the Department Managers reporting daily and allegation of abuse or neglect immediately to the Administrative Staff to ensure timely investigation and reporting. Education will be provided upon new hire and rehire onboarding by the Administrator and Human Resource Director. The Director of Nursing will compile a report based off the monitoring of the 24 hour report and present this report monthly to the Quality Assurance and Process Improvement Committee for 3 months. The Administrator will report monthly a review of any reportable involving abuse and neglect to the Quality Assurance Committee for 3 months.

Date Certain: 7-1-2024

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expectations on preventing, identifying, reporting abuse and neglect.

* The facility has filed a report of the neglect to the licensing agency on 5/13/24.

* The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24.

* The actions the facility will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers.

* Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee).

* The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system which is denoted in the revised Narcan Administration Policy 5/10/24.

The alleged date of immediate jeopardy removal is 5/17/24.

The credible allegation for the immediate jeopardy removal was validated on 5/22/24 with a removal date of 5/17/24.

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A review of in-service education records dated 5/6/24 to 5/11/24 indicated education was provided to all facility staff including contract staff on the policy for Abuse and Neglect Prevention which included staff training expectations on preventing, identifying, and reporting abuse and neglect. Education was also provided to nurses including agency nurses on the activation of emergency response upon administration of Narcan, and ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with staff revealed they had been educated on the facility policy for preventing abuse and neglect. Interviews with the nursing staff including agency nurses revealed they had been educated on activating EMS and notifying the medical provider of any resident who receives Narcan for suspected overdose. The nurses including agency nurses stated they received education on medical emergencies and activation of the emergency response.

A review of the revised Narcan administration policy dated 5/10/24 indicated the nurse who responds to the suspected overdose will direct another staff member to activate EMS.

The facility's date of immediate jeopardy removal of 5/17/24 was validated.

2. Resident #8 was admitted to the facility on 12/20/22 with diagnosis that included chronic obstructive pulmonary disease (COPD), acute respiratory failure, shortness of breath and anxiety.

A review of Resident #8's comprehensive care plan revealed an activities of daily living plan of

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care dated 1/9/23 which included the following interventions:
- The resident requires assistance by staff with personal hygiene.
- The resident requires assistance by staff with toileting.
- The resident requires assistance by staff to move between surfaces.

An Annual Minimum Data Set (MDS) assessment dated 12/16/23 revealed Resident #8 was cognitively intact and was independent for transfers and hygiene. The assessment indicated Resident #8 was independent and continent of bowel and bladder, had no behaviors or rejection of care.

A review of Resident #8's physician's order revealed the following:
- 12/28/23 consult for Hospice services for end stage COPD.
- 1/8/24 Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 0.4 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation.
- 1/15/24 Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 0.5 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation.
- 1/17/24 Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 0.75 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation.
- 1/18/24 Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 1.0 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation.

A nurse progress note written on 1/20/24 at 4:00

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AM by Nurse #2 read as follows:
"Resident is noted to be very busy. He is constantly messing with anything in reach. Objects have been removed for his safety. He is not keeping his O2 (oxygen) in place. Easily anxious with neb (nebulizer) treatments and removes from face. Needs supervision to maintain his O2 placement. Not wanting to take scheduled and routine meds but then easily upset if meds are not given. See MARS (medication administration records) for med administration. Hallucinations off and on. Asking to wear a brief (adult incontinence product) to assist with no movement due to exertion and SOB (shortness of breath). Drinking well. Frequent rounds made. Resident will use call bell at times then he yells out! Call bell is in reach."

An interview with Nurse #2 on 5/7/24 at 4:54 PM revealed she was assigned to care for Resident #8 on night shift from 7:00 PM on 1/19/24 until 7:00 AM on 1/20/24. Nurse #2 indicated Resident #8 was very anxious on that night and she recalled him hallucinating which she assessed to be related to his recent increase in opioid medications. Nurse #2 said although Resident #8 was at baseline continent of bowel and bladder and independent to supervision assistance with toileting, he was more confused that night and staff had convinced him to wear a brief to help him with comfort and to conserve his exertion of him having to get up and down from the bed causing him increase shortness of breath. Nurse #2 stated Resident #8 remained anxious during her shift and she reported these changes to the oncoming nurse at 7:00 AM who she believed to be Nurse #3.

A nurse progress note written on 1/20/24 at 11:47

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AM by Nurse #3 read as follows:
"Res (Resident) is up on side of bed unable to eat lunch due to confusion as well as hallucinations res had a hard time this am with taking breathing treatments writer had to sit with res and hold res hand as well as hold the mask to talk with res due to res felt as if the breathing treatment was suffocating res. Res is crying and tearful due to seeing cats and cars, Res is also wearing a brief at this time due to decline in health status res has made a choice to be comfort measures staff have checked in on resident multiple times this shift. Res is digging through draws (drawers) and making room in disarray as staff walk in throughout checks res is unsure of what he is doing res has had one dose of Morphine (opioid medication used to control pain and aid in breathing during air hunger) this shift as well as morning medications. Staff will continue to check on resident throughout shift."

An additional progress note written on 1/20/24 at 4:43 PM by Nurse #3 read as follows:
"Res was noted to be laying on the bedroom floor res has a gash noted to the left upper arm res also has pain and discomfort noted to the left hip and femur res is unable to move leg or hip area res is in pain and discomfort res on call provider is notified as well as POA (power of attorney) is notified res is sent to ER (emergency room) for treatment and evaluation at this time. DON (Director of Nursing) is notified for the fall."

A review of Resident#8's hospital emergency room report dated 1/20/24 indicated Resident #8 arrived at the hospital via ambulance status post an unwitnessed fall with complaints of pain to his left hip. Resident #8 was comfort care with some confusion noted but expressed desire to have his

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hip fixed due to worsening pain when he moved. The report includes a radiological report from a left hip and pelvis x-ray which resulted in a foreshortened subcapital left femoral neck fracture (most common fracture in the elderly population where the fracture line extends through the junction of the head and neck of the femur) and 4 cm (centimeter) laceration to his left upper arm which required 2 layered repair with sutures. The ER report further detailed he had an increase in lethargy (sluggish) and hypoxia (low levels of oxygen in the blood) in the emergency department and as a result was admitted to the intensive care unit.

Resident #8 was readmitted to the facility on 1/25/24 with diagnoses that included an unspecified intracapsular left hip fracture and chronic respiratory failure with hypoxia.

An interview with Nurse #3 on 5/7/24 at 12:19 PM revealed she was assigned to care for Resident #8 on day shift on 1/20/24 from 7:00 AM to 7:00 PM. Nurse #3 indicated she recalled Resident #8 being very agitated and anxious in the first portion of the shift. Nurse #3 said staff had convinced him to allow assistance to get back in the bed and allow assistance for incontinence by use of wearing a brief to decrease exertion from increase movement and fidgeting. Nurse #3 said she provided him with his medications during the shift but had not provided any incontinence care during her shift. Nurse #3 stated Nurse Aide #18 was assigned to Resident #8 and would have provided him with incontinence care. Nurse #3 said she was standing at her medication cart sometime after her afternoon medication pass was completed and was alerted by Resident #6 (Resident #8's roommate) that she needed to

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come to the room because Resident #8 had fallen to the floor. Nurse #3 explained she rushed down to Resident #8's room to find him lying on the floor on his side and face facing towards the floor, a heavily soiled brief located around his knees and lying in a puddle of urine. Nurse #3 said he had multiple "cuts and gashes" on his body, and he was complaining of severe pain in his left hip. Nurse #3 said she recognized the hip was fractured and immediately initiated calling the emergency medical services 9-1-1 line for transport for evaluation and treatment. Nurse #3 stated she sent Resident #8 to the hospital; she was not aware NA #18 had not provided him with incontinence care and she had not assigned his care to another nurse aide on the unit.

An interview with Nurse Aide (NA) #18 on 5/7/24 at 3:38 PM revealed she was assigned to Resident #8 on 1/20/24 during day shift (7:00 AM to 7:00 PM). NA #18 stated she had gone in to see Resident #18 at approximately 9:00 AM for incontinence care. NA #18 indicated during that care, Resident #8 became very upset and had threatened her to say he would "beat her a**. NA #18 said after completing the incontinence care she left the room and told Nurse #3 about the interaction and that she had concerns about providing him with further care. NA #18 stated Nurse #3 gently reminded her that the behaviors Resident #8 was currently exhibiting were not his morning baseline and if he were himself, he would apologize for what he said that he didn't mean any of it. NA #18 indicated this had not reassured her since his threat had caused her to have flashbacks from personal traumas of her past and therefore, she did not provide any further incontinence care to Resident #8 that day. NA #18 stated she periodically stepped in the

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room to verify that he was breathing until she was called to his room by Nurse #3 stating he had fallen, and she needed assistance. NA #18 said when she arrived at Resident #18's doorway, she saw Resident #8 on the floor with blood on him and the floor, his soiled brief halfway down his legs around his knees and laying in a puddle of urine with his wheelchair resting upon him. NA #18 said this made her feel guilty that she had not provided him with incontinence care, and he had attempted to go by himself as a result. NA #18 said she did not tell Nurse #3 at the time she had not provided him with incontinence care after 9:00 AM that morning.

An interview with Nurse Aide (NA) #20 on 5/7/24 at 9:22 AM revealed that he was not assigned to Resident #8 on that morning (1/20/24) but had gone in to provide him his breakfast tray about 8:00 AM and retrieved a pitcher of tea, a pitcher of water, and a pitcher of ice for Resident #8 upon request at the time of the breakfast delivery. NA #20 said he did not return to Resident #8's room until he was summoned by Nurse #3 shortly after 4:00 PM that afternoon when he was alerted that Resident #8 had fallen. NA #20 indicated he approached Resident #8's room to find him lying on the floor on his side with his brief which was visibly saturated located around his knees and a puddle of urine surrounding him on the floor. NA #20 said Resident #8 was complaining of terrible pain and after initial assessment was sent to the emergency room for evaluation. NA #20 said he was not asked to provide assistance with incontinence care to Resident #8 on 1/20/24.

An interview with the Director of Nursing on 5/7/24 at 12:03 PM revealed she had not been aware NA #18 had not provided incontinence care

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F 600	Continued From page 36 to Resident #8 on 1/20/24 from 9:00 AM until he fell around 4:00 PM. The DON stated incontinence care should be provided to Resident #8.	F 600		
F 609 SS=E	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 reviews, and staff interviews,	F 609	F609	7/1/24

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the facility failed to report suspicious white powder and a pill splitter (device used to cut a pill in half) found in Resident #8's room to local law enforcement after Resident #8 was suspected of drug overdose and was given two doses of Naloxone, also known as Narcan (a medication designed to rapidly reverse opioid overdose in an emergency situation) with positive response. The facility also failed to investigate and preserve potential evidence when they lost the white powder. In addition, the facility failed to submit a complete investigation report and notify Adult Protective Services after Resident #7 alleged abuse from a staff member. This deficient practice affected 2 of 4 residents reviewed for abuse and neglect (Resident #8 and Resident #7).

The findings included:

1. The facility's policy "Abuse Investigations," dated 2017 indicated all reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.

The facility's policy "Reporting Abuse to State Agencies and Other Entities/Individuals," dated 2017 indicated: Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident, including law enforcement officials.

Resident #8 was admitted to the facility on 12/20/22.

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Corrective action for the residents affected by the deficient practice includes:

Immediate action taken for the alleged deficiency:

Resident #8 was discharged from the facility on 3-2-2024.
Resident #7 was seen by the Social Worker on 11/10/2023 with no adverse effects reported. Law Enforcement was notified on 11-9-2023 by the Administrator.

All residents have the potential to be affected by the alleged deficient practice of reporting alleged violations.

Measures put into place to ensure that this alleged deficient does not recur includes the following:

Notification was made to the North Carolina Board of Nursing on 5-13-2024 in regards to Resident #8. Law enforcement was notified of Resident #7 on 11-10-2023.

Education was provided to all clinical nursing staff on the expectations and situations of notifying the Medical Director, Responsible Party, Administrative nursing and the facility Administrator by the Director of Nursing. This inservice was provided on 5-11-2024. Emergency Response Drills were also completed for the direct care clinical staff by the Director of Nursing and Assistant Director

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A review of Resident #8's Medication Administration Record for March 2024 indicated he received
Naloxone liquid 4 milligrams (mg) in nostril on 3/2/24 at 9:34 AM and 9:54 AM. This medication was documented as given by Nurse #14.

A phone interview with Nurse #14 on 5/8/24 at 10:56 AM revealed she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications. Nurse #14 stated she gave Resident #8 the two doses of Narcan which perked him up. After Nurse #14 administered the second dose, she observed that Resident #8's oxygen saturation was within normal limits, and he was talking to her although he said that he was tired and just wanted to lay there in the bed.

A phone interview with the former Social Worker (SW) on 5/8/24 at 12:45 PM revealed she worked as the manager on duty on 3/2/24 when Resident #8 died. The former SW stated she observed Resident #8 slumped over in his wheelchair and she thought he was going to die right there. Resident #8's eyes were pinpoint, and she watched Nurse #14 give Resident #8 two doses of Narcan. The former SW claimed that nobody took it seriously when Resident #8 died because on the evening after he died, staff found a pill splitter with white powder in his drawer when they cleaned his room. The former SW stated this was discussed during the morning meeting on 3/4/24 in which the Administrator was present. The former SW stated that they had been suspecting Resident #8 to be doing drugs because he sometimes acted like he was impaired and was on some other medications not prescribed for

of Nursing on 5-11-2024 to ensure that clinical staff could demonstrate their retention of the provided education. Education was provided to the Administrator on 5-11-2024 by the Consulting Clinical Specialist. The Grievance book was audited for the last 90 days to ensure all allegations have been reported to the appropriate agencies.

The Clinical Nurse Specialist audited the Grievances for the last 90 days to ensure any allegations of abuse have been reported by the Nurse Consultant. This was completed 6-11-2024.

Monitoring will be completed by the the Social Worker and Administrator reporting on the Reportable Investigations, grievances, and the timeliness of reporting to required agencies of any expressed concern alleging abuse, neglect, misappropriation, injury of unknown origin, or seclusion.

A weekly audit will be reported by Social Worker of the grievance book to ensure all allegations have been reported to the appropriate agencies.
The Administrator will report monthly on all reportables and the timeliness of notification to law enforcement and to Adult Protective Services. These notification will be followed up by the reports from Adult Protective Services to validate the contacts made.

Results of the monitoring and audit

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F 609	Continued From page 39 him. The former SW shared that she brought this concern to the attention of the Administrator, but she was told that it was just an assumption, and no investigation was done. A phone interview with Nurse Aide (NA) #3 on 5/9/24 at 4:05 PM revealed she was in Resident #8's room with NA #22 on the evening of 3/2/24 after Resident #8 died. NA #22 found a pill splitter that had a build-up of white powder. NA #3 stated that the white powder looked like remnants from pills being crushed or cut on the pill splitter. NA #3 stated that they stopped what they were doing and turned in the pill splitter with white powder to Nurse #2 who placed it in a reusable plastic bag. NA #3 stated that she and NA #22 searched Resident #8's entire room because they were worried about him having taken medications that were not given to him by the nurse. NA #3 explained that Resident #8 had been caught with vapes in his room in the past and had medication-seeking behaviors. NA #3 shared that after searching Resident #8's whole room, they did not find anything else. A phone interview with NA #22 on 5/9/24 at 6:52 PM revealed that on the evening when Resident #8 died, she and NA #3 cleaned out his room and found a pill splitter with white powder in the third drawer of his dresser. NA #22 stated that she immediately turned it over to Nurse #2 who locked it in the medication room to give to Nurse #14 who was the weekend supervisor the next day. A phone interview with Nurse #2 on 5/7/24 at 4:54 PM revealed on 3/2/24 after Resident #8 died, NA #3 and NA #22 brought her a pill splitter with white powder residue on it to the nurses' station.	F 609	reports will be compiled and presented to the Quality Assurance and Process Improvement Committee for 3 molhts or until the Committee determines compliance. Completion date: 7-1-2024	

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Nurse #2 stated that the nurse aides found it in Resident #8's dresser. Nurse #2 said that she placed both items in a reusable plastic bag along with a note and gave it to Nurse #14, but nothing was done about it.

During an interview with Nurse #14 on 5/10/24 at 8:32 AM, she shared text messages from the nursing leadership chat between the Administrative nursing team consisting of the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the two Unit Managers, and Nurse #14. Nurse #14 stated she reported through the group chat on the morning of 3/3/24 that a pill splitter was found in Resident #8's belongings. The ADON responded with a text message on 3/3/24 at 10:43 AM: "if a pill splitter was found, I don't know how or why." Nurse #14 stated that the pill splitter and the white powder were in two separate plastic bags. She further stated that "there was quite a bit of white powder" in the bag, and it was enough to fill up about one centimeter from the bottom of the plastic bag. Nurse #14 said she put both bags in the former Social Worker's box which was located in the conference room because her office was locked that day, and she couldn't get in it.

A follow-up phone interview with the former SW on 5/10/24 at 11:18 AM revealed Nurse #14 did not put the pill splitter and white powder found in Resident #8's room in her box. The former SW stated that did not even make sense because she was in the building at that time, and if Nurse #14 wanted to hand it to her, she would have given it to her directly. The former SW stated that she never laid her eyes on the pill splitter and the white powder, and if she did, she would have immediately reported it to the Administrator and

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she would have done something about it.

A phone interview with Nurse #21 on 5/9/24 at 11:10 AM revealed she used to be a Unit Manager and she found out about the pill splitter with white powder during the morning meeting on the Monday after Resident #8 died. Nurse #21 stated she couldn't remember if it was given to the former SW, the DON or the ADON, and she did not know if it was disposed of. Nurse #21 stated that the Administrator was present in the morning meeting on 3/4/24. She did not remember the police being notified about the pill splitter and white powder.

During a joint interview with the DON and the ADON on 5/10/24 at 3:29 PM, the ADON stated that she became aware about the pill splitter with white powder on 3/3/24, and she was sure it was talked about in the morning meeting on 3/4/24 with the Administrator present. The ADON stated it was out of her hands, and as far as she knew, it was handled between the former SW and the Administrator.

During a phone interview with the Administrator on 5/9/24 at 11:55 AM, she initially stated that she was not aware that Resident #8 had passed away until the Monday when she came in to work. The Administrator stated that she was not aware of staff finding a pill splitter with white powder and that this was the first time she had heard about it. The Administrator further stated that she did not know that Resident #8 had his own pill splitter in the room and that she would have to look back and see if she had attended the morning meeting on 3/4/24.

2. The facility's policy "Reporting Abuse to State

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Agencies and Other Entities/Individuals," dated 2017 indicated: Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident, including Adult Protective Services (APS).

Resident #7 was admitted to the facility on 6/22/22.

The Incident/Investigation Report by the local county sheriff's office dated 11/9/23 which was not included in the facility's investigation report indicated a text message from Resident #7 to the Unit Manager which read as follows: So, I was just laying here and in comes as--ole to feed me. All he did was slide the tray over to kind of like where my phone is, and he said want to eat? Yeah I said. I didn't even have time to sit up before he crammed the pizza in my mouth and then I kept trying to sit up and he kept pushing me down and he grabbed my tremoring hand and completely made fun of it and then I said, "I want someone else." He said, "You want some money?!!" And when I kept trying to sit up and he kept pushing me back down and saying weird s--t like, "why are you not eating?" when my mouth was so full of pizza from the first bite and then he finally just gave up and left because he said he had more important things to do than sit there and play my games. Also, one of the times he physically forced me down with a piece of pizza in my mouth and I was like choking.

A review of the 5-day investigation report dated 11/14/23 regarding Resident #7's allegation of

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abuse against Nurse Aide (NA) #23 indicated the incident happened on 11/9/23 and the facility became aware of the incident on 11/9/23 at 4:15 PM. Resident #7 reported to the Unit Manager that NA #23 provided inappropriate feeding assistance. It was felt that he was feeding too fast and that he was not taken seriously. NA #23 was immediately removed from the facility. Additional Details included Resident #7 stated that he was fed inappropriately, held down (NA #23 was attempting to keep Resident #7 from coming out of the bed). Resident #7 became belligerent, hostile and NA #23 perceived him as "beating the overbed table." NA #23 reported that since Resident #7's behavior was escalating, he made the decision to leave the room. Another nurse aide was assigned with the resident's meal. The incident was reported to law enforcement on 11/9/23 at 4:30 PM but the notification to the Department of Social Services was blank. Summary of Facility Investigation: After thorough investigation, it was determined that NA #23 concluded that Resident #7 would not require feeding assistance since the meal included finger foods. Resident #7 did self-consume snacks. Resident #7 became combative toward NA #23 and NA #23 left the room.

A phone interview with the former Unit Manager (UM) on 5/6/24 at 1:02 PM revealed that she received a text message from Resident #7 that he had an issue with NA #23. Resident #7 relayed to her through text that NA #23 had come to feed him, made fun of him, fed him too fast, and he started choking. Resident #7 indicated on the text message that when he tried to sit up, NA #23 pushed him back down. The former UM stated that when she received the text message from Resident #7, she was in a meeting with the

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Interim Director of Nursing, the former Social Worker and the Administrator so she went ahead and told them about it.

A phone interview with the Interim Director of Nursing (DON) on 5/6/24 at 12:24 PM revealed the former UM received a text message from Resident #7 which was "alarming" about an abuse allegation against NA #23. The Interim DON stated she completed an investigation by interviewing Resident #7 who indicated to her that NA #23 came into his room, and put his tray down on the bed. NA #23 came back and shoved pizza down into his mouth while he was in a lying position. Resident #7 further alleged that NA #23 took his hand and held him down. The Interim DON stated she did not understand why there was no copy of the text message in the investigation file because she remembered adding it, and she did not know what happened to it. The Interim DON also stated that she ended up unsubstantiating the allegation based on direction from the Administrator, and she was told that the incident was not witnessed.

A phone interview with the former Social Worker (SW) on 5/6/24 at 12:39 PM revealed she was aware of Resident #7's text message to the former UM saying to come help him because NA #23 held him down on the bed with his hand and was trying to force pizza down his mouth. The former SW stated that she was asked to interview the alert and oriented residents regarding abuse after the incident, but she was not asked by the Administrator to notify the social worker at APS.

An interview with the Administrator on 5/6/24 at 4:21 PM revealed she was notified of the situation with Resident #7 by the former UM. The former

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UM told the Administrator that Resident #7 texted her a concern about NA #23 regarding the manner and the way with how he went about feeding him. The Administrator stated she was informed of the text message, but she did not see the text message herself. The Administrator further stated that APS was contacted through the sheriff department.

A phone interview with the APS Social Worker on 5/7/24 at 12:20 PM revealed APS had not received any report within the last 9 months about Resident #7. She stated that she looked in their system and there was no documentation of APS being notified on anything about Resident #7. She added that she even went to the facility on 11/22/23 and nobody approached her to notify her about Resident #7's abuse allegation.

A follow-up interview with the Administrator on 5/10/24 at 4:34 PM revealed she instructed the former SW to notify APS and she thought she did that. When the former UM told her about the text message from Resident #7, she couldn't remember verbatim what the former UM reported to her other than it was a situation in which Resident #7 texted to the former UM that NA #23 had brought the tray, attempted to feed him and it was too fast. The Administrator stated she did not have a reason as to why she did not look at the text message, and that she did not have any reason to disbelieve what the former UM told her. The Administrator stated that she did not see a copy of the text message in the investigation folder and if the Interim DON said she placed one on it, then she probably kept a separate folder. The Administrator continued to claim that she had never seen Resident #7's text message to the former UM.

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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

(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 684 SS=J	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 reviews, and interviews with staff and the Medical Director, the facility failed to initiate emergency medical services for symptoms of a drug overdose. Resident #8 was slumped over, non-responsive with constricted pupils and impaired respirations. Resident #8 was observed by a facility staff member with no heart rate or respiratory rate and was pronounced dead on 3/2/24 at 3:50 PM. This deficient practice affected 1 of 3 residents reviewed for quality of care (Resident #8). Immediate jeopardy began on 3/2/24 when the facility failed to initiate emergency medical services. Immediate jeopardy was removed on 5/17/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: Resident #8 was admitted to the facility on	F 684	Disclaimer notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal Regulations. F684 Quality of Care Resident #8 was discharged from the facility on 3/2/24. All residents have the potential to be affected by the alleged deficient practice of failing to activate the emergency medical response (EMS) for symptoms of drug overdose. Measures put into place to prevent recurrence: A facility look-back audit of 30-days was completed to ensure any resident that was administered Narcan, the medical	7/1/24

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F 684	Continued From page 47 12/20/22 with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, congestive heart failure (CHF), obstructive sleep apnea, anxiety disorder, and panic disorder. Effective 2/29/24 per physician's order, Resident #8's code status was Do Not Resuscitate (DNR). Resident #8's care plan initiated on 1/9/23 indicated the resident had COPD related to history of smoking, had chronic and acute respiratory failure, BiPAP (non-invasive ventilation) at night for obstructive sleep apnea, and oxygen via nasal cannula. Interventions included to monitor for difficulty breathing on exertion, signs and symptoms of acute respiratory insufficiency, and anxiety, and oxygen as ordered. Resident #8 also had a care plan initiated on 1/9/23 that he was on pain medication therapy related to chronic pain, COPD, and severe breathing problems. Interventions included to administer analgesic medications as ordered by physician, monitor/document side effects and effectiveness every shift, monitor for respiratory depression and for increased risk of falls. There was no mention of opioid or Narcan use in Resident #8's care plans. Resident #8 did not have an end of life care plan. A review of the physician's orders in Resident #8's medical record indicated an order for BiPAP with mode/settings: Inspiratory positive airway pressure (IPAP) 22, Expiratory positive airway pressure (EPAP) 18 - Apply at bedtime and remove in morning upon awakening for obstructive sleep apnea. This order started on 6/26/23 and was discontinued to 12/25/23 per recommendations from a pulmonologist as	F 684	provider was notified, and emergency response activated was completed by Nurse Consultant on 5/10/24. No other residents were affected. The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24. Licensed nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed. Agency licensed nurses working at the facility received education on the activating emergency response when administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee).Education was completed on 5-11-2024. The Narcan Administration Policy was revised on 5/10/24, to include activation of EMS. Monitoring will be completed by the following: The Director of Nursing (DNS) will document auditing of the 24-hour report on a daily basis for 2 weeks to ensure that the appropriate activation of emergency medical response (EMS) has occurred. Feedback/education will be provided by the DNS to the licensed nurse addressing any challenges or barriers in the use of Narcan and/or activation of the emergency response as indicated from the daily audit. The results of the 24-hour report documented audit will be presented by the DNS to the QAPI Committee monthly for 3	

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Resident #8 could not tolerate it and the resident wanted to be comfortable.

The significant change in status Minimum Data Set (MDS) assessment dated 2/2/24 indicated Resident #8 was cognitively intact, had no behaviors, had range of motion impairment to one side of the lower extremities, and used a wheelchair. He required supervision to partial/moderate assistance with all activities of daily living (ADL). The MDS further indicated that Resident #8 received both scheduled and prn (as needed) pain medications for complaints of frequent pain at a level of 8 (on a scale of 1-10 with 1 being minimal pain and 10 being severe pain). He had shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat, and used tobacco. He received anti-anxiety, antidepressant, antibiotic, diuretic, and opioid medications. He also received oxygen therapy but was not coded for receiving hospice care.

A physician's order dated 2/29/24 in Resident #8's medical record indicated Naloxone (also known as Narcan) liquid 4 milligrams (mg)/0.1 milliliter (ml) 0.1 ml in nostril every 24 hours as needed for opioid depression/suspected opioid depression (overdose). CALL 911 TO ACTIVATE EMERGENCY RESPONSE. Naloxone liquid 4 mg/0.1 ml in alternate nostril from first dose if no response from first dose. Validate 911 emergency response activated. Nasal Narcan order - Call 911- May repeat dose every 10 minutes as needed for opioid depression/suspected opioid depression (overdose).

A history and physical note documented by the Medical Director on 3/1/24 in Resident #8's

F 684 (Plan of Correction)

months or until the committee determines compliance.

Completion Date: 7-1-2024

Resident #8 was discharged from the facility on 3/2/24.
All residents have the potential to be affected by the alleged deficient practice of failing to activate the emergency medical response (EMS) for symptoms of drug overdose.
A facility look-back audit of 30-days was completed to ensure any resident that was administered Narcan, the medical provider was notified, and emergency response activated was completed by Nurse Consultant on 5/10/24.
The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24. Licensed

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F 684	Continued From page 49 medical record indicated Resident #8 was a long-term care resident who mobilized with wheelchair and was sitting in the hallway. Resident #8 endorsed no complaints of anxiety at this time. He recently was admitted to the hospital for treatment of COPD/CHF exacerbation, and stated he was feeling better after returning to the facility. Review of systems was negative except for cough and shortness of breath. Assessment and plan included COPD - improved since admission to hospital, and CHF - plan to give (diuretic) twice a day for 10 days. A review of Resident #8's Medication Administration Record for March 2024 indicated he received the following medications: * Buspirone (anxiolytic) 5 milligrams (mg) on 3/1/24 at 8:00 PM by Nurse #2 * Trazodone (antidepressant and sedative) 25 mg on 3/1/24 at 9:00 PM by Nurse #2 * Alprazolam (sedative use to treat anxiety and panic disorder) 1 mg on 3/1/24 at 9:00 PM by Nurse #2 * Hydroxyzine (antihistamine used to treat anxiety) 25 mg intramuscularly on 3/1/24 at 9:29 PM by Nurse #2 and 3/2/24 at 3:37 AM by Nurse #2 * Oxycodone-Acetaminophen (narcotic used to treat moderate to severe pain) 5-325 mg on 3/1/24 at 9:26 PM by Nurse #2 and 3/2/24 at 6:28 AM by Nurse #2 * Lorazepam (sedative) 1 mg on 3/1/24 at 9:25 PM by Nurse #2 and 3/2/24 at 6:29 AM by Nurse #2 * Naloxone liquid 4 mg in nostril on 3/2/24 at 9:34 AM and 9:54 AM by Nurse #14 A progress note dated 3/2/24 at 3:01 AM by Nurse #2 in Resident #8's medical record	F 684	nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed. Agency licensed nurses working at the facility received education on the activating emergency response when administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee). The Narcan Administration Policy was revised on 5/10/24, to include activation of EMS. The Director of Nursing (DNS) will review the 24-hour report on a daily basis for appropriate activation of emergency medical response (EMS). Feedback will be provided by the DNS to the licensed nurse addressing any challenges or barriers in the use of Narcan and/or activation of the emergency response. The results of the 24-hour report review will be presented by the DNS to the QAPI Committee monthly for 3 months or until the committee determines compliance.	

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indicated: Resident #8 had been restless just about the entire shift. He wanted to argue about everything. He was so easily exerted with just movement. He was wearing oxygen via nasal cannula. He would not rest in the bed, and sat up on the side of the bed with feet hanging off. Both lower legs and feet were noted to be very edematous. Resident #8 was non-compliant with care. Staff not able to reason with this resident. He was using call bell constantly. See Medication Administration Record for all prn medications and scheduled medications given.

A phone interview with Nurse #2 on 5/7/24 at 4:54 PM revealed she worked with Resident #8 on the night before he died. Nurse #2 stated that he rested occasionally but then he would wake up with breathing problems and would quickly be in a panic. Resident #8 had chronic breathing problems, and he wanted his medications given frequently. Nurse #2 shared that she gave all his medications that she could give that night, but nothing seemed to help his air hunger and he was very anxious. Resident #8 was independent with ADL and was able to go in and out of bed by himself.

A phone interview with Nurse Aide (NA) #24 on 5/6/24 at 3:22 PM revealed she worked with Resident #8 on the night before he passed away. NA #24 stated that Resident #8 had increased shortness of breath that night, and he was very anxious. Resident #8 came to the nurses' station that night and then eventually went back to bed in the early morning.

A progress note dated 3/2/24 at 9:36 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 was given Narcan per

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order. Oxygen saturation 68% (normal value 95% or higher), resident not responding to painful stimuli, pupils constricted. (Small pupils or constricted pupils are common symptoms of opioid overdose.) Narcan given in nostril. Resident now 95% on oxygen. Blood pressure 128/72 (normal value less than 120/80), heart rate 84 (normal value 60 to 100 beats per minute), respirations 18 (normal value 12 to 18 breaths per minute) and regular.

Another progress note dated 3/2/24 at 9:47 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 now resting with eyes closed. Oxygen saturation 98%. No signs/symptoms of pain or shortness of breath.

A phone interview with Nurse #14 on 5/8/24 at 10:56 AM revealed she was working as the weekend supervisor on 3/2/24 when Agency Nurse #20 alerted her. Nurse #20 told her that she had no idea what to do about Resident #8. When Nurse #14 came into Resident #8's room, he was very sweaty and was not responding. Resident #8 was sitting in his wheelchair at his bedside, and he was slumped over. Nurse #14 stated that she was afraid Resident #8 might fall forward off his wheelchair, so NA #20 helped her put him back in bed. Nurse #14 stated that she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications. Nurse #14 further stated she gave him the two doses of Narcan which perked him up. Nurse #14 said she thought Nurse #20 spoke with the on-call provider while she was busy taking care of Resident #8. Nurse #14 also stated that she did not think to call 911 because it seemed like the two doses of Narcan worked,

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and she noted on the physician's order that she could give another dose after 10 minutes if the first one did not work. After Nurse #14 administered the second dose, she observed that Resident #8's oxygen saturation was within normal limits, and he was talking to her although he said that he was tired and just wanted to lay there in the bed. Nurse #14 stated that Nurse #20 told her that she had called the doctor, and she thought that Nurse #20 had also called 911. Nurse #14 commented that she thought Nurse #20 was going to call 911 because Resident #8 was Nurse #20's resident, and after giving Resident #8 the two doses of Narcan, Nurse #14 went back to the other side of the building. Nurse #14 stated that she knew this was Nurse #20's first day working at the facility. She denied having been told by the Social Worker to call EMS after she gave him Narcan. Nurse #14 stated she did not think she needed to call 911 because Resident #8 responded to the Narcan doses, and he was DNR. Nurse #14 further stated that she was not familiar with the facility's policy for Narcan administration and had not received training on how to administer Narcan. She found out later around 2:00 PM that Resident #8 took a turn for the worse but because the ADON told her that morning after she gave him Narcan that Resident #8 was DNR, and that he was dying, she didn't think there was anything else she should have done.

A progress note dated 3/2/24 at 10:00 AM by Agency Nurse #20 in Resident #8's medical record indicated: Resident #8 was sitting up in wheelchair, very difficult to arouse. Oxygen saturation was 71% on oxygen via nasal cannula. Resident #8 was placed back to bed with head of bed elevated. Somewhat more responsive but

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continued to nod off. Oxygen saturation increased to the low 80% with deep breaths. Narcan administered by Nurse #14. Narcan somewhat effective, more alert and verbal. Morning medications held.

A second progress note dated 3/2/24 at 12:58 PM by Nurse #20 in Resident #8's medical record indicated: Resident #8 difficult to arouse at this time. Responded to sternal rub (application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) with mumbles. Oxygen on per order via nasal cannula. BiPAP (bilevel positive airway pressure which is a form of non-invasive ventilation therapy used to help you breathe) placed on. More verbal and alert at this time.

A third progress note dated 3/2/24 at 3:50 PM by Nurse #20 in Resident #8's medical record indicated: Upon observation, no heart rate or respiratory rate noted. Responsible party aware. Nurse Practitioner aware, order to release body to the funeral home received and noted. Funeral home contacted per family request.

A phone interview with Nurse #20 on 5/7/24 at 12:52 PM revealed she took care of Resident #8 on the day he died. Nurse #20 stated Resident #8 was not alert and was unresponsive, so she got Nurse #14 to come in his room to see him and they took his vital signs which were the same vital signs recorded by Nurse #14 in her 9:36 AM progress note. Nurse #20 stated that Resident #8's oxygen saturation level was very low. She could not recall the exact numbers, but she remembered it being in the 70s. Nurse #20 said that Nurse #14 administered Narcan to Resident

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F 684	Continued From page 54 #20. Nurse #20 further stated she was not sure why EMS (Emergency Medical Services) was not notified, and she did not know at the time that EMS was supposed to be notified when Narcan was administered. Nurse #20 shared that she did not look at the order for Narcan because she was not the one who administered it to Resident #8. Nurse #20 recalled Resident #8's pupils being very pinpoint, and he was very lethargic on the day that he died but because Nurse #14 told her that Resident #8 was DNR and that there was nothing else they could do for him, she did not think about calling EMS. Nurse #20 stated she was not familiar with Narcan and had never given it before. She also did not receive training on Narcan administration at the facility prior to her working there. A follow-up phone interview with Nurse #20 on 5/8/24 at 12:26 PM revealed NA #21 alerted her that Resident #8 was lethargic. When Nurse #20 checked Resident #8's oxygen saturation, it was dropping so she asked Nurse #14 for help. Resident #8 woke up somewhat after he received the two doses of Narcan. During the interview, Nurse #20 stated that she was very nervous because she thought that she might be in trouble. Nurse #20 explained that 3/2/24 was her very first day working at the facility as an agency nurse and she did not have access at the time to the clinical messaging platform that the facility used to contact the on-call providers. Nurse #20 stated that she did not think about calling the on-call provider because she thought that Nurse #14 took over Resident #8's care when she gave him the Narcan. Nurse #20 explained that during this incident, she was still trying to get her medication pass done, and she thought Nurse #14 was going to take care of Resident #8. Nurse #20 further	F 684		

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shared that she asked Nurse #14 if they needed to send Resident #8 to the hospital, but Nurse #14 told her no, and that they were not going to do anything for Resident #8 because he was DNR. Nurse #20 clarified that the progress note she documented in Resident #8's chart at 10:00 AM was entered late and that she referred to this note about what happened to Resident #8 before receiving the two Narcan doses. Nurse #20 confirmed that Resident #8 was somewhat more responsive after the two doses of Narcan, but she was not familiar with him because this was her first time taking care of Resident #8, so she did not know what was normal for him. Resident #8 stayed in bed asleep, and his oxygen saturation went up a little, but he got worse in the afternoon when he became lethargic and unresponsive with no heart rate and no breathing. She notified Nurse #14 but again Nurse #14 told her there was nothing they could do for Resident #8. Nurse #20 stated she could not remember why she did not send Resident #8 to the hospital after he received the two doses of Narcan. She did not think of administering the Narcan again and did not think about calling 911. She further shared that she had never administered Narcan before which was why she asked for help from Nurse #14.

A phone interview with Nurse Aide (NA) #21 on 5/7/24 at 11:03 AM revealed on the day that Resident #8 passed away, he was very lethargic, and she told Nurse #20 that he was unresponsive. NA #21 stated that this was not normal for Resident #8 because he was usually up and about and could get around by himself. NA #21 stated that they tried to wake him up multiple times, but he had extremely low oxygen saturation level according to what Nurse #14 and

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Nurse #20 told her. He was wheezing and although she could not recall the exact oxygen saturation, she stated that it was in the 70s based on what she remembered Nurse #20 telling her. NA #21 further stated that they tried to sit him up but over the next few hours, he did not get any better. NA #21 shared that Resident #8 briefly opened his eyes after receiving the Narcan doses but within 20 to 30 minutes he was back to being lethargic. Resident #8 was able to answer questions, but he acted tired and went back to sleep. He continued to have wheezing and a few hours later he was actively dying based on what Nurse #14 told her. She reported this to Nurse #20, and she placed Resident #8 on BiPAP which was at the bedside. NA #21 stated she went on to take care of the other residents on the hall so NA #20 could sit with Resident #8. Then they provided postmortem care to Resident #8.

A phone interview with NA #20 on 5/7/24 at 9:22 AM revealed he took care of Resident #8 when he died. NA #20 stated that it was the most horrific experience he had ever had. Resident #8 sat in his wheelchair and had his head down on the rolling table. Resident #8 was slumped over, and he was jerking in and out of consciousness, so they put him back into bed. NA #20 stated that Resident #8 was not able to speak that day. He was very short of breath. NA #20 reported that Resident #8 usually complained of shortness of breath, but he was always alert and oriented, and he was able to move around in his room by himself. NA #20 said that he told Nurse #14 that Resident #8 was not responding and was lethargic. After Nurse #14 gave Resident #8 the Narcan, he woke up for a few minutes and then after a brief period he was back to being unresponsive. NA #20 added that he continued to

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tell Nurse #20 and Nurse #14 that something was not right with him because his eyes were pinpoint and glazed over even when his head was laid on the pillow. His head was floppy, and his limbs were flaccid. NA #20 further shared that Resident #8 had severe edema in his lower extremities which was worse than usual. He said he attempted to check a pedal pulse on Resident #8 because his legs were so swollen, but he was unable to obtain a pedal pulse for the remainder of the day. He stated that he did not check a pulse anywhere else on Resident #8's body. NA #20 stated that Nurse #14 told him that Resident #8 was actively dying and that there was nothing to be done because he was DNR. NA #20 stated that he stayed with Resident #8 holding his hand because he had known previously that he was afraid of dying alone, and then Resident #8 got quiet and then NA #20 realized that he had passed away. NA #20 hollered for Nurse #20 at approximately 3:50 PM and they came to check on Resident #8 who was pronounced dead. NA #20 provided postmortem care with NA #21 before the funeral director got Resident #8's body.

A phone interview with the former Social Worker (SW) on 5/8/24 at 12:45 PM revealed she was the manager on duty which meant she was in charge of the facility in the absence of the Administrator on 3/2/24. The former SW stated that when she came in that morning around 9:30 AM, Nurse #14 told her that Resident #8's pupils were pinpoint, and that they needed help to put him back into bed. The former SW stated she observed Resident #8 slumped over in his wheelchair and she thought he was going to die right there. Resident #8's pupils were pinpoint, and she watched Nurse #14 give Resident #8 two

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doses of Narcan. The former SW further stated that she told Nurse #14 that the facility's policy was to immediately call EMS, call the doctor and send the resident to the hospital after the resident was given Narcan. The former SW explained that she was training an activity staff member that day, so she left the room after Resident #8 received the two doses of Narcan and she said she thought Nurse #14 was going to send Resident #8 out to the hospital afterwards, but she did not. Later that day, around 2:00 PM, Nurse #14 reported to her that Resident #8 took a turn for the worse, so the former SW asked Nurse #14 if she was going to send Resident #8 out. Nurse #14 did not answer her and just looked at her. The former SW stated that she thought Nurse #14 should know what she was supposed to do because she was the nurse. The former SW stated that she did not want to interfere with nursing because she worked in another department, and she could not tell them what they were supposed to do. The former SW stated that she tried to call the Administrator to alert her as to what was happening in the facility, but she could not get her on the phone.

An initial joint interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/8/24 at 1:11 PM. The DON stated that she was not at the facility when Resident #8 died so she did not remember anything that went on that day. The DON stated that she would have to look back at the notes, but she knew that the former Social Worker and Nurse #14 were at the facility on 3/2/24. The ADON stated that she knew Resident #8 passed away, but it was expected that he was going to die because he had end-stage COPD and respiratory failure. The ADON stated that from

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what she remembered, Resident #8 was found unresponsive, but she denied knowing any details regarding Resident #8 receiving Narcan. The ADON shared that each resident had a standby order for Narcan especially if they had opioid medications in cases of opioid overdose, but she was not sure whether the order indicated that they were supposed to call 911 when administering Narcan. The DON stated that if it was specified on the Narcan order to call EMS, the nurses should have followed what was specified on the order.

A follow-up interview with Nurse #14 on 5/10/24 at 8:32 AM revealed she talked to the ADON after she gave two doses of Narcan to Resident #8 and the ADON told her that it was fine, and that she didn't have to do anything else because Resident #8's code status was DNR. Nurse #14 further stated that if the ADON had told her to call 911, she would have called 911, but because he was DNR, the ADON told her they did not need to do anything. Nurse #14 also shared that around 2:00 PM on 3/2/24 when Resident #8's condition was getting worse, she asked the former Social Worker if she needed to send him out to the hospital. Nurse #14 claimed that the former Social Worker told her that she didn't have to send him out to the hospital because he was DNR. Nurse #14 further shared that Resident #8 had improved after the first dose of Narcan, but she did not know the reason for the persistent lethargy even while he was in bed, so she gave her another dose of Narcan.

A follow-up phone interview with the former SW on 5/10/24 at 11:18 AM revealed she did not say to Nurse #14 not to send Resident #8 to the hospital because he was DNR. The former SW

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stated that it was not her call. She added that Nurse #14 was the nurse on the floor, and she should have taken care of Resident #8.

A follow-up interview with the ADON in the presence of the DON on 5/10/24 at 3:29 PM revealed that the ADON could vaguely remember if she called or texted Nurse #14 on 3/2/24 after Nurse #14 gave the two Narcan doses to Resident #8. The ADON stated that she couldn't remember when her conversation with Nurse #14 was and what time, but that the ADON was not surprised that Resident #8 had died but she was surprised that Nurse #14 had given him Narcan. The ADON stated she questioned Nurse #14 why she gave Resident #8 Narcan when he was expected to die. The ADON explained that she was doing verbal education to the staff to help them understand how sick he was. Whenever Resident #8 had issues with his breathing, he wanted to go to the hospital where they would just give him a rescue BiPAP and intravenous diuretics, and then send him back to the facility. The ADON stated she did not remember her exact response to Nurse #14 about the two Narcan doses, but she recalled Nurse #14 telling her that Resident #8 responded a little bit to the Narcan dose. The ADON further explained that she remembered telling Nurse #14 that Resident #8 was unresponsive because he was actively dying. The ADON recalled Nurse #14 told her Resident #8 responded a little bit after she gave him Narcan.

An interview with the Medical Director (MD) on 5/8/24 at 10:21 AM revealed he last saw Resident #8 on 3/1/24 when he visited him after he had just gotten back from the hospital for COPD and CHF, and he seemed to be doing fine during the visit.

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The MD stated that Resident #8 was a long-term care resident and his plan of care included providing assistive care and managing his chronic medical issues. The MD stated that he was not notified when Resident #8 died but he found out about it the next day he visited the facility. The MD stated that he did not know that they administered Narcan to Resident #8, and he was not familiar with the facility policy for Narcan. The MD stated that if the policy indicated for staff to notify EMS when administering Narcan, then they should have followed that. The MD confirmed that low oxygen saturation and pupil constriction were signs of overdose, and that Resident #8 should have been sent out to the hospital on 3/2/24. The MD added that if an on-call provider was notified about the Narcan doses, then there would be a note in Resident #8's chart and they would have ordered to send him out to the hospital.

Resident #8's death certificate indicated date of death was 3/2/24 and the immediate cause of death was myocardial infarction (heart attack) with the following diagnoses listed as underlying causes: coronary artery disease and congestive heart failure.

A follow-up phone interview with the MD on 5/9/24 at 11:39 AM revealed he put myocardial infarction (MI) on Resident #8's death certificate because that was the most likely cause of his death but if he had known that the nurses had to give him Narcan, he probably would not have put MI without doing further investigation into the cause of his death. The MD stated that he could not put possible overdose on Resident #8's death certificate, and that he would need to have a toxicology report done but this was rarely done unless the family member requested for one to be

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done. The MD stated that a toxicology report could verify the cause of death but since they did not do this anymore, he said he didn't know what he would have put as the cause of death without investigating further. The MD explained that Narcan was just a temporary fix, and it did not fix or correct the cause of the lethargy. Narcan also had a tendency to wear off quickly which was why it could be given every 10 minutes or so, but it would be nice to have EMS around in case the resident went back into depression. The MD added that Narcan was only used in cases of emergency and any resident who received it needed to be observed and monitored closely. The MD further explained that a positive response from Narcan meant that the Narcan was working in terms of reversing whatever caused the unresponsiveness, but it was only effective up to a certain extent.

A phone interview with the Administrator on 5/9/24 at 11:55 AM revealed she was not aware of Resident #8's passing until the Monday when she came in. The Administrator stated Resident #8 had been having repeated respiratory issues, and she knew that he had been advancing with his COPD and that he was end-stage which meant there was not a lot they could do for him. She stated that she knew Resident #8 had just been through two previous hospitalizations for respiratory distress where he received treatment. The Administrator stated that she did not know the specific date that she found out about Resident #8 having been given Narcan without guessing. She could not say whether Resident #8 should have received emergency treatment after receiving the two Narcan doses.

The Administrator was notified of immediate

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jeopardy on 5/9/24 at 12:00 PM.

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:

The facility failed to activate emergency response for Resident #8 after Nurse #14 administered two doses of Narcan on 3/2/24 at 9:34 AM and 9:54 AM with positive response for suspicion of drug overdose.

The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24. Licensed nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed.

The actions the facility will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS to the licensed nurse addressing any challenges or barriers in the use of Narcan and/or the activation of the emergency response.

Re-education was provided to licensed nursing staff about the activation of the emergency response when Narcan is administered.

* Agency licensed nurses working at the facility

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will receive education on activating emergency response when administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee).

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.

The specific actions the facility will take to alter the system failure to prevent a serious outcome from reoccurring are:

* The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24.

* The actions the facility will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers.

* Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee).

* The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system, which is denoted in the revised Narcan Administration Policy 5/10/24.

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F 684	Continued From page 65 The alleged date of immediate jeopardy removal is 5/17/24. The credible allegation for the immediate jeopardy removal was validated on 5/22/24 with a removal date of 5/17/24. A review of in-service education records dated 5/11/24 revealed education was provided to nurses including agency nurses on the activation of emergency response upon administration of Narcan, and ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with the nursing staff including agency nurses revealed they had been educated on activating EMS and notifying the medical provider of any resident who receives Narcan for suspected overdose, and the revised Narcan administration policy. A review of the revised Narcan administration policy dated 5/10/24 indicated the nurse who responds to the suspected overdose will direct another staff member to activate EMS. The facility's date of immediate jeopardy removal of 5/17/24 was validated.	F 684		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		7/1/24

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F 689	Continued From page 66 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and visitor, family, staff, and Medical Director interviews, the facility failed to enforce their smoking policy, monitor a resident who had a history of non-compliance with the smoking policy for storage of smoking materials, and implement interventions to prevent a resident from vaping in his room with his oxygen on and while his roommate (Resident #6) was in the room. Resident #8, who was on oxygen, was found to have a vape pen in his possession on 2/2/24, 2/16/24, and 3/1/24, and was observed vaping while on oxygen on 3/1/24. An electronic cigarette or vape pen (vaporizer) is a device that simulates tobacco smoking. It contains a heating element which reaches high temperatures and can ignite nasal cannula with oxygen flowing. Vaping while on oxygen placed Resident #8 and Resident #6 at increased risk for fire and combustion. This posed a high likelihood of serious injury to all residents. The facility also failed to prevent a resident with moderate cognitive impairment, a history of wandering and exit seeking behaviors, delusional behavior, and delusions from exiting the facility unsupervised and without staff knowledge (Resident #1). Staff interviews revealed an emergency exit door alarm in hallway of the 200 unit sounded around shift change (7:00 AM) on 2/20/24 and staff disarmed the alarm without initiating a "Code Adam" (the facility elopement protocol), without conducting a full resident head count to ensure all residents were in the facility at the time, and without conducting a thorough	F 689	F689 Immediate action taken to address the alleged deficiency: Resident #8 was provided education on the facility's smoking policy on 2-4-2024 by Nurse #3 and the former Social Worker. A smoking contract was completed for Resident #8 on 2-17-2024. All smoking and vaping materials were removed from the resident's room following obtaining his verbal consent on 2-23-2024. The Administrator met with this resident on 2-23-2024 at the request of Resident #8 to discuss the expectation for storing his smoking materials to include cigarettes and vaping materials. The smoking policy was revised on 5/16/24, to include that if a resident who is on oxygen and there is suspicion of not complying with the smoking policy and refuses a room search the facility (Administrator and/or DNS) will notify the police or fire safety of the unsafe situation. These policy revisions and expectations were discussed with the residents that smoke or vape on 5-16-2024 by the Activity Director and Administrative staff. #2. Immediate action taken to address this alleged deficient practice for Resident #1 includes: An immediate head count was completed by the facility staff to ensure that all residents were present in the facility.	

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F 689	Continued From page 67 search of the area which was accessible from the exit. Between 7:05 AM and 7:10 AM, a visitor arrived at the facility and found Resident #1 outside, unsupervised, wearing a thin night gown and socks on her feet, without shoes, and holding multiple pieces of mail. The resident was discovered at the front of the facility approximately 120 yards from the 200 hall exit door. The visitor indicated Resident #1 appeared cold, so he had the resident sit in his car with the heat on until the transportation aide arrived at the facility to open the facility door around 7:30 AM. There was a high likelihood of serious injury from falls and hypothermia as temperatures were recorded at 23 degrees Fahrenheit at the approximate time Resident #1 was found outside. In addition, the facility failed to protect a resident from exposure to an illegal substance. As a result, Resident #6 was found to have experienced altered mental status, impaired physical mobility, and slurred speech. The drug screening test conducted by Nurse #2 confirmed Resident #6 was positive for tetrahydrocannabinol (THC- a compound found in cannabis/marijuana plants). These deficient practices affected 3 of 5 residents reviewed for risk for accidents. Immediate jeopardy began on 2/20/24 for Resident #1 when Resident #1 exited the facility and wandered approximately 120 yards from the exit door in temperatures below freezing (approximately 23 degrees Fahrenheit) outside. Immediate jeopardy began on 3/1/24 for Resident #8 when Resident #8 was observed vaping while on oxygen in the room and the facility failed to have a monitoring system in place for unsecured smoking material. Immediate jeopardy was removed on 5/18/24 when the facility	F 689	Nursing completed a body audit of Resident #1 to record any concerns. No injuries were noted. On 2-20-24 a 100% review of all the facility elopement binders was reviewed to insure accuracy. All books were completed with accurate information pertaining to identified residents at risk for exit seeking behavior. In addition, the Nurse Consultant completed an audit for all residents to ensure that their elopement assessments were updated and accurate. All assessments were accurate. Immediate inservices were initiated by the Social Worker and clinical team on 2-20-2024. Maintenance began an immediate inservice on door alarms and the screamer alarms. Weekly door checks were being completed by the Maintenance Department on 2-20-2024. Residents care plan was reviewed by the Interdisciplinary team and modified with new interventions. 1:1 monitoring was also arranged for increased supervision. This 1:1 increased supervision continued until 2-23-2024 upon the discharge of resident #1. #3. Immediate action taken to address Resident #6: The assigned nurse completed an assessment on Resident #6 and notified the Medical Director. #1. The facility recognizes that all residents that smoke or use vaping materials have the potential to be affected	

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implemented an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of G (actual harm that is not immediate jeopardy) for example # 3.

The findings included:

1. The facility's smoking policy with the revision date of 2/2023 indicated "it is the policy of the facility to allow residents to smoke tobacco-based products in the designated smoking area under staff supervision only. Smoking is allowed only during designated hours and monitored by staff during these times. The designated smoking area is the outside patio. For safety reasons, residents may not possess smoking paraphernalia (including, but not limited to tobacco products which include cigarettes, cigars, pipes along with, electronic cigarettes, lighters, matches, or other smoking material). The aforementioned items must be turned over to facility staff so they may safely store them. Any resident observed not following smoking policies may have their smoking privileges revoked."

Resident #8 was admitted to the facility on 12/20/22 with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure.

A review of Resident #8's Smoking Evaluations in his medical record dated 1/11/23, 1/18/23, 5/5/23, and 2/8/24 indicated Resident #8 was a supervised smoker. The smoking assessments were completed by nurses.

A physician's order dated 1/26/24 in Resident #8's medical record indicated oxygen via nasal

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by this practice.
#2. All residents diagnosed with dementia that exhibit wandering and exit seeking behavior have the potential to be affected by this alleged deficiency.

#3. The facility recognizes that any resident exercising their freewill to leave the facility has the potential to be affected by this practice. The Social Worker completed 100% audit of all residents with legal guardians to ensure that the list is updated and the contact numbers will be made available to the clinical staff.

Measures put into place to ensure that this alleged deficient practice does not recur:

The list of resident smokers, including those who vape, was updated on 5/15/24 by social services. This updated smoking list included the current residents who also vape. The intent of this list is to provide a tool for the staff assigned to supervise the smokers to be able to be a check and balance for any changes.
All residents diagnosed with dementia that exhibit wandering and exit seeking behavior have the potential to be affected by this alleged deficiency.

An audit was completed on 5/15/24 by the Nurse Consultant to ensure that a smoker□s assessment was completed. The audit denoted that 23 smoking assessments required updating. Assessments, which included the safe use of oxygen, were completed on

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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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cannula at 2 liters per minute continuously.

Resident #8's Treatment Administration Record for February and March 2024 indicated he received oxygen via nasal cannula at 2 liters per minute continuously for COPD.

The significant change in status Minimum Data Set (MDS) assessment dated 2/2/24 indicated Resident #8 was cognitively intact, had no behaviors, had range of motion impairment to one side of the lower extremities, and used a wheelchair. He required supervision to partial/moderate assistance with all activities of daily living. The MDS further indicated that Resident #8 had shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat. Resident #8 used tobacco and received oxygen therapy.

A review of Resident #8's medical record indicated no smoking contracts signed prior to 2/5/24. A smoking contract was signed on 2/5/24 by Resident #8 and the former Social Worker and on 2/17/24 by Resident #8, the former Social Worker and Nurse #3.

Resident #8's care plan last reviewed on 2/20/24 indicated the resident had COPD related to history of smoking, had chronic and acute respiratory failure, (non-invasive ventilation) at night for obstructive sleep apnea, and oxygen via nasal cannula. Interventions included to monitor for difficulty breathing on exertion, signs and symptoms of acute respiratory insufficiency, and anxiety.

Resident #8's care plan last reviewed on 2/20/24 indicated Resident #8 smoked and needed to be

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5/16/24.

The Administrator sent out to families/guardians a letter/text message via Cliniconex/Point Click Care (PCC) on 5/15/24 regarding the purchase of cigarettes, lighting materials, and vapes. Families/guardians are to give smoking items to the nurse or activities so they can be secured.

The smoking policy was revised on 5/16/24, to include that if a resident who is on oxygen and there is suspicion of not complying with the smoking policy and refuses a room search the facility (Administrator and/or DNS) will notify the police or fire safety of the unsafe situation

The staff members were educated 5/16/2024 on the revised smoking policy which included residents cannot have cigarettes, lighting material, and vapes on their person, or in their rooms. Education was provided by the Director of Nursing/Assistant Director of Nursing/Unit Managers/Supervisors. All staff, including contract staff, have been educated as to the policy expectations for following steps for ensuring enforcement of this policy. This information was provided by the Administrator and the Director of Nursing. The Administrator educated the Director of Human Resources on 5-17-2024 of updated policy and procedures addressing staff□s conduct if and when they engage in any personal smoking procedures. This includes the disciplinary procedures that will occur in the event

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supervised when he smoked. Interventions included that all smoking materials be kept at the nurses' station and that he would ask to get them before he went outside to smoke. Resident #8 had been informed of the facility smoking policy and staff to remind him as indicated. He needed staff to accompany him to the designated smoking area and staff needed to stay with Resident #8 until he was done smoking and then accompany him back to his unit. The care plan indicated oxygen should be removed before smoking.

A Social Services note in Resident #8's medical record dated 2/4/24 indicated on Friday, (2/2/24), at 12:00 PM, the Social Worker (SW) was notified Nurse #3 that Resident #8 had a vape in his room. The Social Worker and Nurse #3 went in and removed it.

A phone interview with the former Social Worker (SW) on 5/9/24 at 10:15 AM revealed Resident #8 was non-compliant with the facility's smoking policy. Resident #8 was observed with a vape pen in his room on 2/2/24, but she couldn't remember if he was observed using it. Nurse #3 removed the vape pen from Resident #8's room. The former SW reported Resident #8 had been educated on the facility's smoking policy and she was responsible for completing the smoking contracts. The former SW stated she did not know why there wasn't a smoking contract in his medical record prior to 2/5/24. She also stated that she did not know where the resident was getting his vape pens from.

A phone interview with Nurse #3 on 5/6/24 at 2:37 PM revealed on 2/2/24, she observed a vape pen on Resident #8's bedside table. She notified the

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these policy expectations aren□t followed. Staff smoking policy expectations has been added to the employee onboarding checklist to document that this policy has been reviewed and understood.

Residents who smoke and utilize oxygen were educated on removal of oxygen prior to going outside to smoke or vape by the Director of Nursing/Assistant Director of Nursing/Unit Managers/Supervisors on 5/16/24. Reminders will be given upon each designated smoking time to all smoking and vaping residents by the assigned staff members providing supervision.
Education was provided to all smoking residents by social service, the activity department and Administrative staff on 5/16/24 on the smoking policy and the policy and procedures of failure to abide by safety requirements.

A smoking attendance sheet was created for any staff supervising the assigned smoking times. This list contains names of all residents that either smoke or vape. Notation is made on the attendance sheet of who attends. This is to assist in ensuring that all smokers have been identified and the residents have been educated as to the safe smoking expectations. Any resident whose name does not appear on the list will be asked to have a smoking assessment and education provided prior to smoking.

Smoking assessments will be completed by the clinical team for each newly

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F 689	Continued From page 71 former SW and they both removed it from the room. Nurse #3 stated she did not observe Resident #8 vaping in his room with his oxygen on, but he was educated that he could not keep his vape pen in the room. Nurse #3 stated Resident #8 would not tell them how he obtained the vape pen. Nurse #3 further stated that Resident #8 had vape pens removed from his room many times after 2/2/24, and he also had cigarettes that he kept in his room which he smoked outside in the patio. Nurse #3 stated she did not know how Resident #8 was obtaining the vape pens and the cigarettes. Nurse #3 stated that she notified the former SW after all the times she removed vape pens from Resident #8's room. She shared that a staff member was supposed to be outside when the residents were smoking but unfortunately, they had to pass out three cigarettes for each smoker and a lot of times, there was approximately 20 residents out there at a time. So therefore, they were not able to keep an eye on the residents to ensure they were not smoking things or takings things they were not supposed to be sharing. A review of a Smoking Policy/Contract signed by Resident #8 and the former Social Worker on 2/5/24 indicated the following information under Violation: Resident Policy Enforcement - 1. First Resident Infraction: Immediate notification of the Administrator and the Director of Nursing (DON) of any suspected/known smoking policy infraction, completion of an incident form with witness statements and full investigation of the infraction, prompt meeting with the resident by members of the Interdisciplinary Team (IDT) to review the smoking policy violation and the smoking policy once again, re-performance of the smoking	F 689	admitted resident upon admission, quarterly and as needed. #2. Education and training on Elopement Prevention, Processes and Procedures were provided to the facility staff by the Nurse Manager and the Social Work Director on 2-20-24. Agency staffing will be contacted prior to accepting their scheduled shift and the policy and procedures for elopement prevention. A vendor for monitored alarming system has been initiated. This alarming system will be with the intent to install a wanderguard system for increasing resident safety. In-services are to be completed by Human Resources to all new hires. Nursing staff who did not receive the education will not be allowed to work until education is provided. Any identified resident that is exhibiting an issue with behavioral changes, pacing, will be Referred to our psychological contracted services for an evaluation and recommendations. #3. Education on notification was provided to the clinical nursing staff on 4-24-24 by the Director of Nursing. Monitoring will be completed by the following: The smoking supervisors will maintain a smoking attendance record of all smoking residents who have attended the designated smoking assigned times. The Activity Director will compile a list of the smoking sheets and will present a	

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assessment and individualized safe smoking plan for comprehensiveness, and a written witnessed warning regarding the infraction.
2. Second Resident Infraction: Immediate notification of the Administrator and the DON of any suspected/known smoking policy infraction, completion of an incident form with witness statements and full investigation of the infraction, prompt meeting with the resident by member of the IDT to review the smoking policy violation and the smoking policy once again, re-performance of the smoking assessment and individualized safe smoking plan for comprehensiveness, and revocation of smoking privileges for up to two weeks.
3. Third Resident Infraction: Immediate notification of the Administrator and the DON of any suspected/known smoking policy infraction, completion of an incident form with witness statements and full investigation of the infraction, prompt meeting with the resident by members of the IDT to review the smoking policy violation and a discussion regarding a discharge plan which may include thirty day discharge notice and plan, revocation of smoking privileges, and coordinate a resident discharge plan with the resident/resident representative to a setting that may be more suitable to his/her goals.

A progress note dated 2/16/24 at 11:00 PM documented by Nurse #2 in Resident #8's medical record indicated that she removed vapes that were on Resident #8's bedside table. Nurse #2 notified the SW.

A phone interview with Nurse #2 on 5/7/24 at 4:54 PM revealed she observed two vape pens on Resident #8's bedside table on 2/16/24, and confiscated them right away. Nurse #2 stated that

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report to the Quality Assurance and Process Improvement Committee for 3 months.

#2. Continued monitoring of care is completed daily through routine clinical rounds conducted by the Unit Managers and Director of Nursing as well as rounds completed by Contracted Clinical Consultants. The monitoring includes observation of providing activities of daily living, and day-to day interaction with residents including those resident□s with behavioral issues.
The Social Worker or Designee will interview at least 5 residents a week for 4 weeks to determine if any identified residents are exhibiting exit seeking behavior.
Continued door alarms and exit / elopement drills will continue for each shift to complete observations of resident responses to potential eloping residents Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing and/or Administrator where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.
#3. The Director of Nursing will review the 24 hour report on a daily basis to monitor for any reports of residents that show a significant change in behavior and condition. Results will be compiled in to a clinical report and reported to the Quality Assurance and Process Improvement

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F 689	Continued From page 73 Resident #8 was yelling loudly and would not stop that night. He wanted his vape pens back and was mad because he could not have them. He was short of breath, and had oxygen in place. Resident #8 argued with Nurse #2 about not having his vape pens and he was upset because Nurse #2 would not give them back to him. Resident #8 even went on to say that Nurse #2 "was to ignore his vapes and let him have them." Nurse #2 stated she notified the former SW about the vape pens which were at the bedside. A phone interview with Nurse Aide (NA) #3 on 5/9/24 at 4:05 PM revealed she had caught Resident #8 with vape pens in his room in the past, and she reported this to the nurse who would confiscate the vape pen. NA #3 stated there was one time in February 2024, but she couldn't remember the exact date when she observed Resident #8 sitting up in his bed and he requested to have his urinal emptied. NA #3 stated that as she entered the room, she observed Resident #8 holding a vape pen in his hand while he had his oxygen on, and when she confronted him about it, he denied having the vape pen. Resident #8's roommate was also in the room at that time. NA #3 explained that she observed Resident #8 holding the vape pen, but he was not vaping at that time, and she reported this to Nurse #2. NA #3 stated that Nurse #2 confiscated the vape pen and then the former Social Worker talked to Resident #8 first thing the next morning. NA #3 stated that she knew other staff members had observed a vape pen laid out in Resident #8's bedside table, and they had told the Administrator about this concern, but nothing was done about it. NA #3 stated that she knew the residents were not supposed to have vape pens in their rooms, and that Resident #8 was not	F 689	Committee for 12 weeks. Completion date: 7-1-2024	

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supposed to be vaping with his oxygen on.

A Social Services Note dated 2/17/24 at 4:59 PM indicated Resident #8 was caught the night of 2/16/24 with two vape pens. The SW met with him this morning and informed him that this was his third time with smoking items in his room. Resident #8 signed his third smoking agreement. He asked if he could have a smoking patch and it was ordered for him.

A follow-up phone interview with the former SW on 5/10/24 at 11:18 AM revealed she talked to Resident #8 on 2/17/24 about the two vape pens that were found in his room on 2/16/24. Resident #8 would not tell her where he obtained the vape pens. The former SW stated that Resident #8 signed his third smoking agreement on 2/17/24. She further stated that it was hard to enforce Resident #8's smoking contract, and they were unable to follow the consequences after each infraction because she did not have support from the interdisciplinary team. The former SW stated all she could do was meet with Resident #8 and have him sign another smoking contract. Resident #8 agreed to quit smoking at that time, and he wanted to be started on a smoking patch. The former SW shared that after a few days, the smoking patch did not work because Resident #8 started refusing to have it on, and he wanted to go back to vaping and smoking.

A progress note documented by Nurse #2 on 2/19/24 at 6:42 AM indicated Resident #8 had been very anxious this entire shift. He was short of breath with exertion off and on. Resident #8 had bragged about smoking again and refused the Nicotine patch. He also bragged about having someone bring him in a new vape and cigarettes.

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SW aware.

Another progress note documented by Nurse #2 on 3/2/24 at 3:01 AM indicated Resident #8 continued to vape as desired then he wanted staff to "fix" his breathing. Staff unable to reason with this resident.

A phone interview with Nurse #2 on 5/7/24 at 4:54 PM revealed when she took care of Resident #8 on the night of 2/19/24, he was easily short of breath more than usual, and he was very anxious. He bragged about having someone bring him in a new vape pen and cigarettes, and that he had started smoking and vaping again. Nurse #2 stated she did not observe a vape pen in Resident #8's room on 2/19/24, but she went ahead and notified the former SW about what Resident #8 said to her. Nurse #2 also stated that she worked with Resident #8 on the night of 3/1/24, and he wanted his medications given frequently. Nurse #2 stated that she gave Resident #8's medications as often as possible, but they did not seem to help his air hunger and he was very anxious. She also stated that occasionally he rested but then would wake up with breathing problems and would quickly be in a panic. Nurse #2 further stated that Resident #8 continued to vape in his room even with his oxygen on, and he refused to hand over the vape pen to her that night. Nurse #2 stated that Resident #8's roommate was in the room at that time. Nurse #2 said that she reported this to the former SW that evening through a text message. Nurse #2 stated the former SW came in the next morning and removed the vape pen from Resident #8's room. Nurse #2 stated she was aware that Resident #8 should not be vaping with his oxygen on, but he refused to give it to her,

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and there was nothing else she could do.

A phone interview with NA #22 on 5/9/24 at 6:52 PM revealed she had seen Resident #8 on the night of 3/1/24, and he was vaping in his room with an oxygen on while his roommate, Resident #6, was inside the room. Resident #8 refused to give the vape pen to Nurse #2. NA #22 stated she knew the weekend supervisor talked to Resident #8 the next day about not vaping in the room. NA #22 stated she knew Resident #8 should not vape with his oxygen on, but he refused to hand it over to them that night.

A Social Services Note dated 3/2/24 at 1:19 PM indicated the SW was informed by Nurse #2 that Resident #8 had been using a vape during the night but would not give them to the nurse. The SW and Unit Manager went in and talked with the resident, and he gave them his vape, but he would not tell where he got it.

A phone interview with the former SW on 5/20/24 at 4:09 PM revealed Nurse #2 had sent her a text message, but she did not receive it until in the morning of 3/2/24 while she was on her way to the facility. The former SW explained that she did not get good phone service at her place, and did not often receive text messages until she was closer to the facility. The former SW stated that as soon as she saw Nurse #2's text message about Resident #8 refusing to turn in his vape pen, she went to Resident #8's room and talked to him about not having vape pens in his room. The former SW stated that she confiscated four vape pens from Resident #8's room that morning. She added that she tried to call the Administrator on 3/2/24, but she could not get her on the phone.

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A phone interview with NA #20 on 5/7/24 at 9:22 AM revealed Resident #8 wore oxygen and was a supervised smoker in the outside patio, but NA #20 often found vape pens in his room. NA #20 stated that whenever he found Resident #8 smoking a vape pen in his room with his oxygen on, he would tell Nurse #2 or the Social Worker who would confiscate the vape pens. NA #20 said he could not remember the specific dates he had observed Resident #8 smoking a vape pen with his oxygen on, but he knew that he was not supposed to be doing that. NA #20 stated that he knew that according to the smoking contract, Resident #8 was supposed to lose his smoking privileges, but he never did.

An interview with Nurse #14 on 5/10/24 at 8:32 AM who was the weekend supervisor revealed she always observed Resident #8 vaping in his room with his oxygen on. Nurse #14 stated that she would often smell the vape, and she would confiscate it from Resident #8. Nurse #14 stated that she had no idea where Resident #8 was getting his vape pens from, but she always reported this to the former SW to whom she turned in the confiscated vape pens. Nurse #14 confirmed that she removed the vape pen from Resident #8's room on the morning of 3/2/24, along with the former SW.

Resident #6, roommate of Resident #8, was admitted to the facility on 11/5/19. The quarterly MDS assessment dated 3/29/24 indicated that Resident #6's cognition was intact. An interview with Resident #6 on 5/22/24 at 2:45 PM revealed he never saw Resident #8 use a vape pen while he was using his oxygen. Resident #6 stated that Resident #8 never gave him a vape pen, and he

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never asked him for one.

A phone interview with the former Social Worker (SW) on 5/9/24 at 10:15 AM revealed when vape pens were found in Resident #8's room, she would re-educate him and let him sign a new smoking agreement. The former SW stated that the Administrator would not let them revoke Resident #8's smoking privileges or issue a discharge notice even when he had repeated violations of the smoking contract. The former SW stated that she placed the confiscated vape pens in the bottom drawer in a filing cabinet in her office which she always kept locked.

During a joint interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/10/24 at 2:34 PM, the DON stated that the Social Worker handled the smoking contracts while nursing handled the smoking assessments. When a resident violated their smoking contract, this was dealt with by the Social Worker and the Administrator. The DON stated that she did not know enough about vape pens, and that she did not know whether it was unsafe if a resident vaped while he was on oxygen. The ADON stated this would have been dealt with immediately, but she had not seen this happen. The DON stated that the nurse could take the vape pen away if they felt that it was a safety hazard, and that they would have to contact the Social Worker. The ADON stated that she was aware that staff saw vape pens in Resident #8's room, but she was not sure whether they belonged to him or his roommate. The DON stated that the residents were allowed to vape in the designated smoking area but not inside their rooms. The DON stated the vape pens and cigarettes were supposed to be locked

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up, and the residents were not supposed to have them in their person. The ADON added that they had a lot of smokers at the facility, and it was hard to control them.

An interview with the Administrator on 5/10/24 at 4:34 PM revealed she was aware of staff finding vape pens in Resident #8's room but she couldn't tell when they first found them. The Administrator stated it happened on more than one occasion. Staff told the former SW that Resident #8 had a vape pen in his room, and she went in to talk to him, but she didn't know what she had explained to Resident #8. The Administrator shared that she talked to Resident #8 shortly after he signed his third smoking contract, and she told him that he could vape, but the vaping materials would need to be locked up. The Administrator said that they had multiple discussions and reviews of the smoking policy with Resident #8, but she could not enforce the smoking policy and issue him a discharge notice because they could not find an appropriate place for him. The Administrator stated that when it came down to it, they needed to go through the proper discharge. She added that most of their residents would breach the smoking policy, and all they could do was to continually monitor and observe, and ask for their cooperation.

A follow-up interview with the Administrator on 5/22/24 at 4:35 PM revealed she was aware of an event where the nurse aides observed or suspected Resident #8 of vaping while he was on oxygen, and the nurse aides notified the former SW. The former SW interviewed Resident #8 about vaping with his oxygen on, but he would not give up his vape pens. Resident #8 said he should be able to vape when he wanted to, and

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he did not think vaping was in the same category as smoking. The former SW told the Administrator about this the following week right around the same time he was sent out to the hospital. The Administrator further stated that when Resident #8 came back from the hospital in February 2024, he asked her if he could vape, and she told him that he could, but he would have to go outside and follow the smoking policy, and he could not keep the smoking/vaping materials in his room. The Administrator said she did not know that Resident #8 had vape pens until the nurse aides and the former SW observed him with them, and he did not want to give them up until the former SW talked to him. The Administrator also stated that there was not a point where she thought about revoking Resident #8's smoking privileges because he had been compliant and honest with her.

The Administrator was notified of immediate jeopardy on 5/15/24 at 10:54 AM.

The facility submitted 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:

The facility failed to enforce their smoking policy and implement interventions to prevent a resident (Resident #8) from vaping in his room with his oxygen on and while with a roommate in the room.

Electronic cigarettes or vape pens contain a heating element which reaches high temperatures and can ignite nasal cannula with

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oxygen flowing. Vaping while on oxygen placed Resident #8 and his roommate at increased risk for fire and combustion. This had a high likelihood of serious injury to all residents.

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.

The facility needs to have effective systems in place to supervise residents while smoking, enforce their smoking policy, and prevent residents from keeping smoking paraphernalia in the rooms. The facility needs to have monitoring systems in place for unsecured smoking material.

* The list of resident smokers, including those who vape, was updated on 5/15/24 by social services. This updated smoking list included the current residents who also vape. The intent of this list is to provide a tool for the staff assigned to supervise the smokers to be able to be a check and balance for any changes.

* An audit was completed on 5/15/24 by the Nurse Consultant to ensure that the smokers' smoking assessments were completed. The audit denoted that 23 smoking assessments required updating. Assessments, which included the safe use of oxygen, were completed on 5/16/24.

* The Administrator sent out to families/guardians a letter/text message via Cliniconex/Point Click Care (PCC) on 5/15/24 regarding the purchase of cigarettes, lighting materials, and vapes. Families/guardians are to give smoking items to the nurse or activities so they can be secured.

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* The smoking policy was revised on 5/16/24, to include that if a resident who is on oxygen and there is suspicion of not complying with the smoking policy and refuses a room search, the facility (Administrator and/or DNS) will notify the police or fire safety of the unsafe situation.

* The staff were educated on 5/16/2024 on the revised smoking policy which included that residents cannot have cigarettes, lighting material, and vape pens on their person, or in their rooms. Education was provided by the Director of Nursing/Assistant Director of Nursing/Unit Managers/Supervisors. All staff including contract staff, have been educated as to the policy expectations for following steps for ensuring enforcement of this policy. This information was provided by the Administrator and the Director of Nursing. The Administrator educated the Director of Human Resources on 5/17/24 of the updated policy and procedures addressing staff's conduct if and when they engage in any personal smoking procedures. This includes the disciplinary procedures that will occur in the event these policy expectations aren't followed. Staff smoking policy expectations was added to the employee onboarding checklist to document that this policy has been reviewed and understood.

* Residents who smoke and utilize oxygen were educated on removal of oxygen prior to going outside to smoke or vape by the Director of Nursing/Assistant Director of Nursing/Unit Managers/Supervisors on 5/16/24. Reminders will be given upon each designated smoking time to all smoking and vaping residents by the assigned staff members providing supervision.

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* Education was provided to the smokers by social service on 5/16/24 on the smoking policy and the policy and procedures of failure to abide by safety requirements.

The alleged date of immediate jeopardy removal is 5/18/24.

The credible allegation for the immediate jeopardy removal was validated on 5/22/24 with a removal date of 5/18/24.

A review of in-service education records dated 5/16/24 revealed education was provided to staff on the revised smoking policy which included for residents not being able to have cigarettes, lighting material, and vape pens on their person, or in their rooms. Interviews with the staff including contract staff revealed they had been educated on the policy expectations for following steps for ensuring enforcement of the smoking policy, especially for residents who used oxygen. Interviewed staff verbalized understanding that residents who used oxygen should never smoke or vape at the same time, and that oxygen should be removed prior to smoking or vaping.

A review of the smoking policy revised on 5/16/24 indicated if the resident is on oxygen therapy and refuses to allow the facility to conduct a room search, the police will be notified of the unsafe situation.

An observation of smoking on 5/22/24 at 1:37 PM revealed there were 18 residents in the smoking porch. There was a container by the door to the smoking area for oxygen storage, but no oxygen tanks were present. Two staff members were

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observed assisting the smokers with applying smoking aprons, and providing cigarettes and lighting them for the residents. No resident was observed smoking while on oxygen, and none were observed vaping. All lit cigarettes were disposed of in the appropriate containers in the outside patio at the end of the session.

Interviews with residents who smoked and/or vaped revealed they were educated on the smoking policy and about not keeping smoking items such as cigarettes, vapes, and lighters in their person and in their rooms. They also stated understanding regarding the importance of not smoking or vaping while on oxygen or while in close proximity to another resident on oxygen.

A review of the audits completed on 5/15/24 indicated the smoking list was updated to include residents who also used vape pens. Smoking assessments were completed on 5/16/24.

A review of medical records of residents who smoked and/or vaped revealed the residents and family members were advised not to bring smoking materials including vape pens to the residents in the building, and instead, to turn them in to the nurse or start an account with the business office who would purchase smoking materials for them. They were also reminded that the residents were not allowed to have any smoking material including vape pens on them or in the rooms, and that all smoking materials must be given to the nurse or activities so that they could be safely stored.

The facility's date of immediate jeopardy removal of 5/18/24 was validated.

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2. Resident #1 was admitted to the facility on 7/23/23 with diagnoses that included dementia with agitation, bipolar disorder, anxiety disorder, insomnia, history of falling, difficulty walking, unsteadiness on feet, muscle weakness, panic disorder, schizoaffective disorder, and cognitive communication deficit.

A review of the facility floor plan revealed Resident #1 resided on the 200 hall unit near the 100/200 hall nurses station and approximately 7 resident rooms from the 200 hall emergency exit door.

An elopement risk assessment was completed on the following dates prior to her recent readmission: 8/1/23 and 11/26/23. Resident #1 was determined to be at risk for elopement on both assessments.

A review of Resident #1's Admission/Readmission Nursing Assessment dated 12/15/23 revealed she had risk alerts for falls and may attempt to exit with wandering listed under mood and behaviors.

A review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 12/17/23 revealed Resident #1 had moderate cognitive impairment. Resident #2 was not coded with wandering behaviors during the 7-day lookback and required supervision for ambulating 50 feet and make 2 turns.

A review of Resident #1's care plan revealed the care plan was initiated on 7/19/23. She was care planned for exit seeking behaviors and elopements and read in part; It is unsafe for me to leave this facility; however, I may attempt to do

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so. 8/1/23-trying codes on exit doors and the following interventions implemented: 1) When you find me trying to leave, please check to see if I am looking for a specific place or thing. If appropriate, help me to find it. If it is not appropriate, distract me. 2) Perform an elopement assessment on me quarterly and as needed should my cognitive or physical situation change 3) Make sure that my picture is in the elopement book on every floor and in the main lobby. 4) Divert to activity 5) Check on me often and when you do your hourly safety rounds. 6) 15-minute checks until behaviors stops 7) 1:1 until behaviors stops or discharge.

An interview with Nurse #10 on 4/24/24 at 8:38 AM revealed she recalled working with Resident #1 on the night of 1/27/24 from 7:00 PM to 1/28/24 at 7:00 AM. Nurse #10 said that although Resident #1 did not exit the facility on that evening she did recall her pulling the fire alarm and pushing on the emergency exit door in an attempt to at one point to exit the facility but was unsuccessful to open the door and redirected by staff.

A nurse progress note dated 2/2/24 at 6:06 AM written by Nurse #11 indicated Resident #1 had shown behaviors where she expressed the desire to go outside and stated, "Satan was coming after her if she didn't go outside right now." The note indicated staff attempted to redirect Resident #1 by notifying her it was too cold to go outside at the time but Resident #1 continued to go into other resident's rooms to ask them to take her outside.

A telephone interview with Nurse #11 on 4/26/24 at 4:21 PM revealed she recalled working with Resident #1 on 2/2/24 when Resident #1

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expressed her need to go outside due to Satan coming after her. Nurse #11 stated Resident #1 frequently referred to Satan coming to get her or someone being outside and her need to go outside but had not exited the facility during her shift on 2/2/24.

A review of the incident report logs dated 1/1/24 through 4/23/24 revealed no elopement reports for Resident #1 documented.

A telephone interview with Visitor #1 on 4/22/24 at 4:55 PM revealed he had arrived at the facility the morning of 2/20/24 at approximately 7:05-7:10 AM to visit a resident at the facility. Visitor #1 stated when he arrived that morning before sunrise (documented sunrise was 7:14 AM), he noticed a female walking and stopping at the front of the facility holding a large handful of mail and wearing nothing but a short-thin cotton night gown, he described as "It was hardly fit for sleeping indoors," and no shoes. Visitor #1 stated he immediately thought about how frigid the temperatures were outside, thought she looked cold, and he stopped his automobile near the female and Visitor #1 said he attempted to ask Resident #1 where she was trying to go. Visitor #1 recalled Resident #1 told him she was attempting to "go to Asheville," (which was approximately 55 miles away) so he asked her to get in his vehicle to wait with him until Transportation Aide #1 arrived at the facility that morning so she would not freeze to death and maybe [Transportation Aide #1] could take her. Visitor #1 stated Resident #1 willingly entered the front seat of Visitor #1's car and he turned on the heater as high as possible to warm her back up after being in the cold air for an unknown amount of time. Visitor #1 said Resident #1 sat in his car

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talking until Transportation Aide #1 arrived between 7:25-7:30 AM that morning to let them in the building. Visitor#1 said when the transportation aide arrived that morning, he recalled telling Transportation Aide #1 that he had found the resident alone outside holding the mail from the mailbox. Visitor #1 said he remembered saying, "[Transportation Aide], I stopped and let her in before she froze to death out here." Visitor #1 stated he offered to escort Resident #1 upstairs to her room for the transportation aide because he was going that way, but Transportation Aide #1 asked him to stand with her while he clocked in, then they both escorted Resident #1 upstairs. Visitor #1 said Resident #1 stood with him and Transportation Aide #1 at the 300/400 hall nurses' station while they spoke to the nurses (Nurse #2 and Nurse #3); then he left and went to visit his family member who resided in the facility and left Resident #1 with Transportation Aide #1.

A review of the recorded weather on AccuWeather for the area of the facility during the night of 2/19/24 for the facility revealed the temperatures was approximately 23 degrees Fahrenheit around 7:00 AM without precipitation on the morning of 2/20/24 when Resident #1 was returned to the facility.

A telephone interview with Transportation Aide #1 on 4/22/24 at 5:14 PM revealed he arrived at the facility on 2/20/24 at approximately 7:25 AM. He stated he was always the first staff member to arrive in the front entrance to the facility and he unlocked the door each morning and allows Visitor #1 to enter daily to visit his family. Transportation Aide #1 stated on the morning of 2/20/24, he quickly gathered his belongings to get

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to the door, but as he approached the front entrance, he noticed a female exiting the passenger side door of Visitor #1's automobile and was bent over gathering something from the front seat wearing a "short mini skirt and her legs shining." The Transportation Aide stated he stood there initially startled because Visitor #1 did not usually have anyone accompany him to the facility but within moments the female turned around and looked at him, yelled out "[Transportation Aide], I got your mail." The Transportation Aide stated she began walking towards him carrying an arm full of mail and handed it to him. The Transportation Aide said he asked Visitor #1 what occurred, and Visitor #1 had informed him that when he arrived that morning, he noticed Resident #1 was in front of the facility carrying the mail with a limited amount of clothes on and he was concerned she would freeze so he stopped his car and had her get in until someone arrived. The Transportation Aide stated he and Visitor #1 escorted Resident #1 back into the facility and upstairs where he then took Resident #1 back to her unit and asked a nurse aide (he could not recall her name) if she was "missing anyone?" He then informed the nurse aide Visitor #1 had located Resident #1 outside near the front entrance and had her in his car until the Transportation Aide arrived. The Transportation Aide said he asked the nurse aide if she looked outside for any residents, and she said NA #3 looked around but did not see any residents outside and was unsure if a resident had exited the facility at the time.

A handwritten statement dated 2/24/24 written by Nurse Aide (NA) #1 read as follows: "the door alarms on 200 hall started going off I want to say between 7:05 AM and 7:15 AM. NA#2 and I

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walked to the end of the hall to see why the alarm was going off. As we got to the end of the hall, we didn't see anyone near the door and NA #3 came down the hall probably a minute later because we couldn't turn the alarm off. She (NA #3) asked if anyone went outside and checked, and we (NA #1 and NA #2) said no, and NA #3 cut the alarm off. NA #2 walked right (I'm not sure how far right) then she walked left to the dining room and stated she didn't see anyone. NA #3 and I walked back up to the front and that was the end of what happened until [Transportation Aide #1] brought Resident #1 up at about 7:30 AM-ish."

An interview with Nurse Aide (NA) #1 on 4/22/24 at 3:58 PM revealed she was scheduled to work on the 200 hall where Resident #1 resided on the night of 2/19/24 from 7:00 PM to 7:00 AM the morning of 2/20/24. NA #1 stated she was an agency NA and began working in November or December of 2023 and had recently transitioned to be a facility employee. She stated she was familiar with Resident #1, she knew Resident #1 had a history of exit seeking behaviors, Resident #1 frequently said she needed to leave the facility for various surgeries and most recently "breast surgery," and believed her family was outdoors to transport her to her appointments. She said around shift change (7:00 AM) she heard an alarm going off and she and NA #2 followed the sound and located it to be the emergency exit door at the end of the 200 hall. NA #1 said neither she nor NA #2 knew the code to turn off the alarm that was sounding so another nurse aide (NA #3) came down the hall about that time from another unit and asked if anyone went out the door. NA #1 said both she and NA #2 had not seen anyone exit from that door so they both said "No". NA #3 turned off the alarm. NA #1 said NA #3 told NA #2

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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 689	Continued From page 91 to check to make sure no resident had gotten outside even if she had not seen anyone exit by "taking a quick look outside." NA #1 said she recalled NA #2 being reluctant but went outside and walked briefly to the right of the emergency exit door and to the left and quickly returned into the facility though the cafeteria door (emergency exit door in the kitchen/dining room area which required a key pad code for entry) and said she did not see anyone outside. NA #1 said NA #3 then left the facility as her shift was completed and she said she was getting ready to leave herself at approximately 7:30 AM when she heard staff paged to come to the 300/400 hall nurses' station. NA #1 said she stayed on the hall with the residents and NA #2 responded to the page. NA #1 said she was asked to continue to work on the 200 hall until 11:00 AM when NA #2 abruptly returned to the unit and said she was leaving the facility and would not be returning to work and therefore she continued to work with Resident #1 until 11:00 AM on 2/20/24. NA #1 said later in the shift she was asked to write a statement of what occurred with the alarm at shift change. NA #1 stated shortly following the page on the intercom, Transportation Aide #1 escorted Resident #1 onto the 200-hall unit wearing a short green cotton night gown and said Resident #1 needed to be watched closer because she had exited the facility and Visitor #1 had found her outside the facility. NA #1 said around that time (7:30 AM-7:45 AM), Nurse #5 had arrived on the unit for her shift and was walking towards them and Transportation Aide #1 explained to Nurse #5 what occurred. NA #1 said Nurse #5 then took Resident #1 from Transportation Aide #1 and took her to her room. NA #1 said Resident #1 was initially placed on every 15 minutes checks; however, she continued to attempt to exit the	F 689		

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facility and wander off the unit at times. NA #1 said she was difficult to redirect and had increase agitation the remainder of her shift.

A telephone interview with NA #2 on 4/24/24 at 11:08 AM revealed she was no longer employed with the facility and had not worked at the facility since 2/20/24. NA #2 stated she thought she heard an alarm sounding when she arrived to work on the morning of 2/20/24 at shift change (7:00 AM) as she had approached the nurses' station at the 100/200 hall desk, and she sat her bag down. NA #2 said she looked around and no other staff seemed alarmed so she initially thought it must be the alarm on the back door where staff entered and exited and continued to obtain shift to shift report from the night shift nurse aide (NA #1). NA #2 said after approximately 30-60 more seconds she continued to hear the noise, she and NA #1 looked at each other and realized the alarm was not coming from the staff exit (a designated locked door in the rear of the facility where staff enter and exit the facility) but another door and proceeded towards the 200 hall and towards its emergency exit door. NA #2 said she and NA #1 quickly reached the 200-hall emergency exit door and attempted to disarm the alarm but did not know the code to turn off the alarm. NA #2 said she did not see any residents in the general proximity of the door on the interior or exterior of the facility from the door while trying to disarm the alarm. NA #2 explained around that time, NA #3 approached them and asked if anyone went outside. NA #2 said both she and NA #1 said they had been giving reports and had not seen anyone near the door and did not see anyone outside. NA #2 said she was asked to go outside and take a look around. NA #2 stated NA #3 opened the door

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and let her out the door and she said when she exited the 200 hall emergency exit door she walked towards the right side of the facility to the 300/400 hall storage area (a covered awning used on the exterior of the building to store unused furniture and equipment) which was approximately 25-50 feet from the exit door to the right and located in the direction of the front of the facility, then returned towards the staff parking lot (across from the exit door) and returned into the facility through the dining room entrance at the rear of the facility (approximately 50 feet to the left of the 200 hall exit door). NA #2 stated she did not see any residents while she was outside and therefore believed the alarm had sounded faulty from the wind as had occurred before (alarm would sound when door had not been fully opened due to excessive suction from the wind which forced a crack in the door enough to set off the maglock system) until she overheard staff announce to come to the 300/400 hall for a meeting. NA #2 said she told NA #1 to stay on the 200-hall unit and she would respond to the page, so she left the unit and proceeded to the 300/400 hall unit as requested. NA #2 said when she arrived at the 300/400 hall nurses' station, she learned that Resident #1 had exited the facility and been found outside the facility by Visitor #1. NA #2 said Resident #1 was at the 300/400 hall nurses' station with Transportation Aide #1 when she arrived in a short green cloth gown but was then taken to the 200-hall unit during the meeting.

A handwritten statement dated 2/20/24 at 8:45 AM written by Nurse Aide #3 (NA #3) read as follows: "7:05 AM- leaving at the end of my shift 300 hall going to the time clock- when I reached the conference room, I heard a door alarm and a screamer (small battery powered alarm which

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sounds like a siren when activated) going off. I reached the 100/200 hall desk at the same time as NA #4 did coming from the opposite direction. She (NA #4) and I together turned down to 200 to see NA #2 and NA #1 attempting to silence both alarms. As I am coming towards them, I am yelling and motioning for them both to go outside to see if someone had gone out. NA #2 hesitated, then said Really and I stated yes. I watched her exit and turn right, walk a distance, turn back left, walk a distance, and come back towards the door shrugging her shoulders. By now I had the screamer turned off and the door alarm and motion for her to go around the building to come back in. I then asked NA #4 and NA #1 whose rooms were in this back corner and NA #4 stated [Resident 7]. I asked if she thought he could have pushed the door and she replied no, and NA #1 follows by saying I thought it was Resident #1 but she's in the TV room. I made it back to the 100/200 hall desk now and see Nurse #1 walking on 200 hall side of the desk I believe her to being aware and I clocked out and left. I left honestly believing it was a fault in the door. There have been several occasions that 400 hall door has popped open just enough from wind to sound the door alarm. Having personally watched NA #2 outside looking seeing no one and NA #1's statement that Resident #1 was in the TV room I clocked out thinking it was a fault in the door as I've experienced on 400 hall."

A telephone interview with Nurse Aide (NA #3) on 4/24/24 at 8:55 AM revealed she was assigned to work the 400 hall on the night shift (7:00 PM of 2/19/24 to 7:00 AM of 2/20/24). NA #3 stated on the morning of 2/20/24 she gave report to the day shift nurse aide and both she and NA #4 had retrieved their belongings and were walking along

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F 689	Continued From page 95 the corridor between the wings that separate the 300/400 hall from the 100/200 and lead to the staff exit at the back of the facility. NA #3 stated when they had reached the conference room area on the hall, she heard a noise that sounded like an alarm, so she continued to walk towards the 100/200 hall until she realized the noise was an alarm sounding from an emergency exit door on the 200 hall. NA #3 said when she reached the opposite end of the 200 hall where the door was located, she saw both NA #1 and NA #2 at the opposite end of the 200 hall near the door attempting to disarm the alarm, but neither were successful, so she proceeded towards them. NA #3 said when she approached NA #1 and NA #2 she asked them if anyone had exited the facility through that door and they looked at one another and both answered by shaking their heads no. NA #3 said she asked if any of the residents who resided near the exit door could have opened the door and said she recalled asking about Resident #1 specifically and was told by NA #1 she had saw her earlier in the shift with another resident reading the Bible in the activity room on the unit. NA #3 said she told NA #2 to go outside just to make sure a resident had not gone outside, and she would disarm the emergency exit alarm for her. NA #3 said NA #2 then exited the facility and proceeded outdoors as far as she could see towards the right and then came back in front of her to the left and back in the facility through the dining room door shrugging her shoulders and said she did not see anyone out there. NA #3 said she thought the alarm may have sounded "faulty" (alarm would sound when door had not been fully opened due to excessive suction from the wind which forced a crack in the door enough to set off the maglock system) as had occurred in the past and she left the facility since her shift was	F 689		

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completed. NA #3 said a little later that morning she was contacted by Social Worker #1 where she learned Resident #1 had eloped from the facility and she was asked to return to write a written statement of what she recalled that morning, so she returned to the facility to write the statement at around 8:45 AM.

A handwritten statement dated 2/20/24 written and signed by NA #4 read in part as follows: "I was at the desk giving NA #2 report and heard a loud noise. We didn't know what it was because we had never heard it before, but we followed the sound and seen it was the unit 200 hall exit door. NA #1 and NA #2 ran down to the door as I waited on NA #3 who was walking toward me, and we went down to give the girls the code as NA #3 was the only one who knew it that was right there. NA #2 walks out to the right and didn't see anybody and then walked to the left to the parking lot to come inside through the dining room. As me, NA #1 and NA #3 were coming back up the hall we were thinking someone pushed the door; even joked that [resident not on the sample] did it because it was so quick, and we didn't see anyone. Even mentioned Resident #1's name as we walked by and observed her door still closed as it was left on the last round but never thought she had gotten out and down the hill that fast!"

Multiple attempts to interview Nurse Aide #4 during the investigation were unsuccessful.

A telephone interview with Nurse #2 on 4/23/24 at 5:22 PM revealed she had been assigned to work 300/400 hall during night shift (7:00 PM to 7:00 AM) on the night of 2/19/24 into the morning of 2/20/24. Nurse #2 stated she recalled on the

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F 689	Continued From page 97 morning of 2/20/24 around 7:30 AM, she was providing shift to shift report to Nurse #3 at the 300/400 hall nurses' station (opposite side of the building from the 200 hall) when she looked up to notice Visitor #1, Transportation Aide #1 and Resident #1 get off the elevator and approach the nurses' station. Nurse #2 indicated Visitor #1 began to explain that he arrived at the facility to see his family member, but this morning he noticed Resident #1 was standing outside alone. Nurse #1 stated Visitor #1 told her and Nurse #3 that he noticed she was not dressed appropriately for the weather and was concerned for her safety since she appeared confused when he spoke to her. Nurse #2 said Visitor #1 had explained he convinced Resident #1 into sitting in his car where it was warm until Transportation Aide #1 arrived to let them in the building that morning. Nurse #2 said she did not appear injured, so she immediately began attempting to call the facility administration beginning with the Director of Nursing (DON), who did not answer. Nurse #2 said she then attempted to contact the Assistant Director of Nursing (ADON) and could not reach her. Nurse #2 said she made a second attempt to reach both the DON and the ADON without success before reaching out to Social Worker #1 who answered the phone immediately. Nurse #2 said Social Worker #1 told her to make sure Resident #1 was safely returned to her unit and have nurses complete a full facility headcount. Nurse #2 said that Social Worker #1 said she would attempt to contact the Administrator who was at a conference and would come to the facility as soon as possible. Nurse #2 said once she hung up with Social Worker #1, both she and Nurse #3 called staff over the intercom to the 300/400 hall nurses' station to request they begin conducting a headcount for resident	F 689		

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accountability and to see if anyone may possibly know how Resident #1 had gotten out of the building. Nurse #2 said when staff arrived at the 300/400 hall nurses' station, she learned that an alarm had sounded on the 200-hall unit around shift change.

A telephone interview with Nurse #3 on 11/23/24 at 11:04 AM revealed she was assigned to work the 400 hall on day shift (7:00 AM to 7:00 PM) on 2/20/24. Nurse #3 said she had arrived at work that morning and began shift to shift report with Nurse #2 when Visitor #1 and Transportation Aide #1 approached the floor from the elevator escorting Resident #1. Nurse #3 explained when she saw Resident #1, she was wearing a short green cotton gown and thin socks on her feet and carrying an arm full of what appeared to be mail. Nurse #3 said Visitor #1 immediately asked her and Nurse #2, "Who is responsible for this woman?" He was referring to Resident #1 and began telling both Nurse #2 and Nurse #3 he found her when he arrived at the facility that morning (2/20/24) between 7:05 AM and 7:10 AM and stopped to ask her what she was doing outside. Nurse #3 went on to say both she and Nurse #2 had asked Visitor #1 where he had found Resident #1. She indicated Visitor #1 told them he found her "down the road" and "kept her safe" in his car until Transportation Aide #1 arrived at the facility to let them in the facility. Nurse #3 explained Visitor #1 thought she appeared cold and said he had to "warm her up" because he didn't want her to "freeze to death" in the bitter cold air outside. Nurse #3 said when Resident #1 did not appear injured from being outside, they instructed Transportation Aide #1 to take Resident #1 back to her room and make her nurse (Nurse #5) aware she had exited the facility

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and needed monitoring more closely to ensure she did not get out again. Nurse #3 said Transportation Aide #1 escorted Resident #1 back to her unit at that time while both she and Nurse #2 tried to contact the facility's administrative team to let them know what occurred. Nurse #3 said both she and Nurse #2 attempted to contact both the Director of Nursing (DON) and Assistant Director of Nursing (ADON) multiple times without success and tried contacting the Administrator once via telephone unsuccessfully before they reached out to Social Worker #1. Nurse #3 said Social Worker #1 instructed her and Nurse #2 to start conducting a head count to determine if all residents were accounted for in the facility and she would be to the facility in about half an hour or so since staff were unable to reach the DON and ADON. Nurse #3 said after hanging up the phone with Social Worker #1, both she and Nurse #2 called staff over the intercom to the 300/400 hall nurses' station to initiate a headcount. Nurse #3 indicated she and Nurse #2 had begun interviewing staff about their knowledge of what happened on that morning (2/20/24) and learned an alarm sounded on the 200 hall emergency exit door around shift change (7:00 AM).

A telephone interview with the Social Worker #1 on 4/23/24 at 12:07 PM revealed she was no longer employed at the facility. She explained she was familiar with Resident #1 and initiated the investigation conducted on 2/20/24 after Resident #1 exited the facility through the 200-hall emergency exit on the unit. Social Worker #1 indicated she was contacted via telephone around 7:30 AM on 2/20/24 by Nurse #2 and Nurse #3 who informed her that Resident #1 had somehow exited the facility and was found

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F 689	Continued From page 100 by Visitor #1 outside near the front of the building in the cold and he returned her to the facility when Transportation Aide #1 arrived at the facility that morning. Social Worker #1 said she immediately told Nurse #2 and Nurse #3 to begin a headcount of all residents in the building to make sure no other residents had exited the building at the same time and she would be to the facility in about 30 minutes. Social Worker #1 said she arrived at the facility at approximately 8:00 AM that morning and began to collect statements from staff who were present in the facility. Social Worker #1 said when the administrative nurses (DON and ADON) arrived later in the morning between 8:30 AM - 9:00 AM, they assisted in the investigation at that time. Social Worker #1 indicated she contacted the Administrator and notified her of Resident #1's exit from the facility on the morning of 2/20/24. A telephone interview with Maintenance Director #1 on 5/5/24 at 5:50 PM revealed he was no longer employed by the facility; however, he recalled the events on 2/20/24 regarding Resident #1 exiting the facility. Maintenance Director #1 stated he learned of the elopement on the morning of 2/20/24 when a member of the nursing administration team (identified by Maintenance Director #1 to be the Assistant Director of Nursing) communicated an alert on 2/20/24 at 7:48 AM via an external social media communication application called "WhatsApp" used by facility staff. Maintenance Director #1 stated after he arrived at the facility on the morning of 2/20/24, he checked all emergency exit doors to ensure the alarms were functioning properly and assisted with in-service training by initiating education on the screamer alarms. He said he was able to provide education to available	F 689		

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members of staff on day shift. Maintenance Director #1 said he had previously expressed concerns to administration that he had noticed staff ignored alarms. Maintenance Director #1 indicated he had performed an external audit of the external perimeter of the facility where Resident #1 would have traveled from the 200 hall emergency exit door to the front of the facility where the mailbox was located which he described as approximately 150-200 yards and included a steep declining roadway leading to the front parking lot which he was sure Resident #1 had traveled on the morning of 2/20/24 and stated it would have been almost impossible for Resident #1 to have traveled to the front of the facility through the grassy as due to the grade of the hills and uneven surfaces required.

A review of the electronic screenshot messages of the alert provided by Maintenance Director #1 was reviewed and revealed the following messages:

- Huge problem girls...We had an elopement! [Resident #1] got out 200 hall door no one checked to see if someone went out just turned alarm off ...and [Resident #1] was walking down the road. Family member picked her up outside and brought her back in."
- "It's 24 degrees outside and [Resident #1] was wearing just a shirt."
- "She's prolly going to need 1:1 until Bx [behavior] stops. She knows how to get out now."
- "[Assistant Director of Nursing] call me."

On 4/23/24 at 7:55 AM, accompanied by Transportation Aide #1, an observation of the area surrounding the 200 hall emergency exit door revealed immediately upon exit of the 200

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hall emergency exit door was a paved walkway approximately 10 feet that connects to an adjacent road which lead to a staff parking lot or down a steep hill with a blind curve area leading into the lower parking lot and lead out the road exiting the facility to the main road at the highway. The area where Resident #1 was found by Visitor #1 was at the front of the facility. A concrete area which contained a flagpole, and a mailbox were observed which were next to the road that served as the facility ambulance entrance, staff parking lot, and was along the road entrance into the facility with a posted speed limit sign of 25 miles per hour.

An observation and demonstration of the emergency exit door alarm system accompanied by Maintenance Director #2 on 4/22/24 at 2:30 PM revealed a metal door at the end of the hallway. The door was equipped with a maglock system which allowed the door to open after pressing on the handle which was located approximately waist high for 15 seconds. This caused the door to release with an audible but low decimal pitch alarm. Once the door was fully opened, a second alarm was activated, a high pitch siren type alarm began to sound until the door was closed and a code was pressed into the key pad located above the top of the left side of the door. The alarm systems were not electronically wired into an enunciator panel elsewhere in the facility and must be manually disarmed by a staff member.

An interview with Nurse #1 on 4/22/24 at 4:20 PM revealed she was the Unit Manager for the 100/200 halls. Nurse #1 stated she had counted narcotics and received report from Nurse #7 at around 6:45 AM when Nurse #7 had to leave her

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shift early on 2/20/24. Nurse #1 assumed the responsibility for 200 hall until Nurse #5 arrived around 7:30 AM. She said she was in charge of Resident #1's care at the time of the elopement but said she could not recall any residents in the hallway nor had she heard any alarms sounding on the morning of 2/20/24. Nurse #1 said between 7:30 AM- 7:45 AM she heard the intercom page staff to the 300/400 hall and was approached by NA #1 around the same time who informed her that Resident #1 had exited the facility and been found by Visitor #1 that morning. Nurse #1 said following being notified that Resident #1 had exited the facility, she did a head count of her unit to ensure the residents on the 100-hall unit were all visualized. Nurse #1 said after she counted all her residents, she noticed Nurse #5 near the 200 hall emergency exit door and an alarm was going off, but the sound was very faint and was barely loud enough to be heard at the 100 hall nurses' station. Nurse #1 said the alarm could not be heard until she began to approach Nurse #5 on the 200-hall unit. Nurse #1 described the alarm as a low-pitched humming sound and only became louder near the emergency exit door. Nurse #1 said she did not visualize Resident #1 on 2/20/24 and did not perform a head-to-toe skin assessment after she was returned to the unit that morning.

An interview with NA #9 on 4/23/24 at 10:26 AM revealed she was assigned to work day shift (7:00 AM to 7:00 PM) on 2/20/24. NA #9 said she was assigned the unit Resident #1 previously resided on and was very familiar with the resident's behavior of wandering and constant exit seeking. NA #9 stated Resident #1 frequently returned to her unit even after she was transferred to the 200-hall unit on the opposite

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side of building. NA #9 stated staff were called to the 300/400 hall nurses' station for a meeting on the morning of 2/20/24 and told to do a head count to make sure all residents were accounted which she participated. NA #9 indicated following Resident #1's exit of the facility, when in-service training was provided it consisted of handing a staff member a form to sign and not being provided any visual education or training. NA #9 said she only knew which residents were at high elopement risk if she had made observations or received a shift-to-shift report from the proceeding nurse aide.

An interview with NA #10 on 4/23/24 at 11:49 AM revealed she worked through an agency on the adjacent unit (100 hall) to the unit where Resident #1 resided (200 hall); however, she was familiar with Resident #1 and her wandering behaviors. NA #10 said Resident #1 frequently ambulated in the hallway with an unsteady gait and voiced her desire to leave the facility. NA #10 explained she was made aware Resident #1 exited the facility on the morning of 2/20/24 through shift-to-shift report that night.

An interview with NA #14 on 4/23/24 at 9:53 AM revealed she worked on the 200-hall unit where Resident #1 resided on night shift (7:00 PM on 2/20/24 to 7:00 AM on 2/21/24). NA #14 said when she arrived on duty, she was made aware Resident #1 exited the facility on the morning of 2/20/24. NA #14 explained that evening Resident #1 was assigned to a nurse aide (NA #4) to have visual checks every 15-minute checks on Resident #1.

An interview with the Assistant Director of Nursing (ADON) on 4/24/24 at 4:40 PM revealed she was

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aware Resident #1 had exited the facility on 2/20/24 but was not in the facility at the time of the event. The ADON stated she was notified on the morning of 2/20/24 between 7:30- 8:00 AM that Resident #1 had exited the facility and Visitor #1 had found her outside. The ADON stated during the telephone conversation that those were the only details of the event she was aware of until she arrived at work that morning. The ADON said when she arrived on duty on the morning of 2/20/24, she learned Resident #1 had exited the facility through the 200-hall emergency exit door. She stated the screamer alarms sounded and NA #2 responded; however, the ADON indicated she was notified when she arrived that NA #2 performed a facility external search for any residents who may have exited that morning but did not see anyone before returning in the facility. The ADON explained when she learned of the elopement, she attempted to contact the Administrator but was unsuccessful.

An interview with the Director of Nursing (DON) on 4/24/24 at 4:40 PM revealed she was aware Resident #1 had exited the facility on 2/20/24 but was not in the facility at the time of the event. The DON stated she recalled Nurse #2 and Nurse #3 had attempted to reach her via phone that morning unsuccessfully. The DON said when she arrived on duty on the morning of 2/20/24 she learned Resident #1 had exited the facility through the 200-hall emergency exit door. She stated the screamer alarms sounded and NA #2 responded and had performed a limited search of the external facility before returning into the facility through a door in the back of the facility. The DON stated Resident #1 was sent out to the hospital later in the shift on 2/20/24 and when she

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returned, she was placed on every 15 minutes checks followed by initiation of 1:1 sitting by staff.

An interview with the Administrator on 4/24/24 at 5:15 PM revealed she was aware Resident #1 had exited the facility on 2/20/24; however, she was not in the facility at the time of the event. The Administrator indicated Resident #1 exited the facility on the morning of 2/20/24 through the 200-hall emergency exit door and ambulated from the 200-hall emergency exit door to the front of the facility and had retrieved the mail from the facility mailbox when Visitor #1 found her. The Administrator indicated Resident #1 returned unharmed and was discharged to a local assisted living facility a couple days following the event.

An interview with the Medical Director (MD) on 4/24/24 at 3:11 PM revealed he became the medical director around the time Resident #1 had exited the facility and he was made aware Resident #1 had exited the facility on 2/20/24 when she was sent to the emergency department where he was a provider for increase agitation and behaviors; however, he was not contacted at the time she exited the facility. The MD stated Resident #1 being outdoors for extended periods of time without appropriate attire could have resulted in hypothermia and her ambulating down the steep hill adjacent to the facility where the 200-hall emergency door exits the facility put her at high risk of injury from falls due to unsteady gait and without appropriate footwear.

Multiple staff members (Nurse #1 through Nurse #17 and Nurse Aide #1 through Nurse Aide #17) provided information through interviews about the training they received. The interviewees discussed the training provided and detailed

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training did not include visual training and often they stated they were handed a blank inservice sheet and were told to sign it without any education provided.

The Administrator, Director of Nursing and the Assistant Director of Nursing were made aware of the immediate jeopardy on 4/24/24 at 5:35 PM.

The facility submitted the following credible allegation of immediate jeopardy removal:

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

The facility failed to prevent a resident with dementia, and a history of wandering/exit seeking behaviors from leaving the facility unsupervised and without staff knowledge through the 200-hall emergency exit for 1 of 3 sampled residents (Resident #1). Staff interviews revealed that on 2/20/24 an exit door alarm went off in the morning and staff turned it off around shift change (7:00 AM). A head count was not conducted at that time.

The protocol for missing resident (Code Adam) was not initiated at that time. Around 7:05-7:10 AM, a visitor arrived at the facility and saw Resident #1 outside, unsupervised, wearing a thin cotton night gown, collecting the mail at the front of the facility approximately 120 feet from the 200 hall exit door.

The visitor indicated Resident #1 appeared cold so he had the resident sit in his car with the heat on until the transportation aide arrived at the facility to open the facility door.

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On 2/20/24 Resident # 1 was assessed by the Assistant Director of Nursing and noted to be at baseline. Vital signs were stable upon return to the nursing unit.

An immediate facility wide resident head count was conducted confirming all residents to be safe in the facility. This head count was initiated by the Director of Nursing and the Assistant Director of Nursing on 2-20-24.

On 2-20-2024 and again on 4-25-24 the Director of Nursing and the MDS Coordinator conducted a risk audit to further identify any residents at risk for elopement. The elopement risk audit that was completed on 4/25/24 resulted in the deactivation of two residents that no longer presented to be an elopement risk. Additionally, one resident was identified as having the potential risk for elopement as a result of this additional audit. Elopement risk plans are in place for those identified to be at risk for elopement. These plans were reviewed by the Interdisciplinary Team on 4-25-2024. The Members of this team include the MDS Coordinator, Director of Nursing, Assistant Director of Nursing, Social Worker, Activity Director, and the Rehabilitation Director.

An investigation was launched which included staff interviews with all staff members. The Director of Nursing directed this investigation. The investigation was completed 2-21-24. The results of this investigation revealed that there was a delay in the direct care staff recognition of the location of Resident #1. The Direct Care Staff identified in this incident self-terminated upon this occurrence. Facility staff received reteaching on the expectations of preventing facility

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elopements. This teaching was provided to facility staff by the Maintenance Director on 2-20-24. The content of this education included the following content: Recognizing Code Adam as the facility's announcement that a facility search to confirm all residents are present must begin immediately and our elopement protocol. The elopement protocol outlines the actions that staff will take to manage any elopement concerns which involve, completion of a resident headcount, skin assessment to the involved individual upon return to the facility, obtaining statements from all staff as to any observations. Staff were informed that notifications of the elopement have to be made to the resident's representative, Medical Director, Administrator and Director of Nursing immediately. Facility doors and alarms are to be checked to make certain that they are functioning properly. Education also included information on the location and contents of the elopement binders. It was explained that these binders hold information on the facility residents that have been assessed upon admission, change in condition, and quarterly of resident's at risk for eloping. Picture identification is located in this binder to help staff identify each resident. This information was reviewed with the Human Resources Director by the Maintenance Director on 2-20-24 to reiterate that this education was being completed upon orientation and with new hires. Elopement Prevention was added to the onboarding checklist for newly hired employees, agency personnel and contracted clinical staff to document receipt of this information.

On 2-20-24 a 100% review of all the facility elopement binders was conducted by the facility Social Worker to ensure accuracy. Findings

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confirmed that all elopement binders were complete with accurate information pertaining to identified residents at risk for exit seeking behavior. In addition, the Nurse Consultant completed an audit 2-20-2024 for all residents to ensure that their elopement assessments were updated and accurate. All assessments were accurate and reflected the resident's exit seeking risk.

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.

Staff re-education was conducted on 2-20-24 by the Social Worker, Director of Nursing, Assistant Director of Nursing and the Maintenance Director, regarding elopement risk binders, reporting exit seeking behaviors promptly to supervisors/management and response to sounding exit alarms for all staff. The Human Resources Director tracked agency and contracted staff by auditing the daily scheduling sheets. Heightened awareness was confirmed by the ability of the staff's correct responses to questioning of the educational material. This inservice was provided to all facility and contracted staff scheduled on 2-20-2024.

The Maintenance Director conducted an inservice on 2-20-2024 on door alarms and the screamer alarms for all staff. These in-services provided education on the appearance of the door alarms, how the alarms work, how to activate, deactivate and reset the codes to the alarming systems. The purpose of applying and using the alarms was reviewed with the direct line staff, as well as all ancillary staff members. Weekly door checks for

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functionality are conducted by maintenance staff without noted variance. Any system failure of the door or the alarm systems was recorded by the Maintenance Director and resolved. The expectations of all staff's response to all door alarms was reiterated during these educational sessions.

On 2-20-2024 Resident # 1's care plan was reviewed by the Interdisciplinary team consisting of the Social Worker, MDS Coordinator, Rehabilitation Director, Director of Nursing, Assistant Director of Nursing and enhanced measures were promptly implemented. These enhanced measures included the Director of Nursing initiating 1:1 monitoring by staff of Resident #1. Staffing was scheduled by the Scheduler to denote the staff assigned to provide this supervision. In addition, placement options were discussed and reviewed for Resident #1. These options took into account the level of care required by Resident#1, as well as the need for a secure unit in which the resident's independent functioning could be enhanced. The Guardian for Resident #1 was notified of this plan and was in agreement. The Facility Staff were informed of this plan of discharge through shift reporting on 2-20-24 by the Social Worker. This resident was discharged to an Assisted Living Facility 2-23-2024. This transfer provided Resident #1 with a secure unit.

Nursing staff who did not receive education by 2-20-2024 will not be scheduled until the in-service and education has been completed. In addition, any newly hired employee also received this education as a part of their onboarding. This will be tracked for accuracy by the Human Resource Director and Scheduler.

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The facility will explore the placement of surveillance cameras at exit doors for enhanced safety. The facility is securing pricing on a monitoring alarming system for residents at risk for elopement. Efforts will be initiated by the Nursing Home Administrator on 4-24-2024.

On 2-20-2024 the Director of Nursing and Assistant Director of Nursing reviewed the designed tools implemented to assist in a review of 24-hour reports and shift to shift handoff reports that are used to communicate any incident, event or change in condition of any resident that may have occurred. These reports are brought to the morning meeting by the Director of Nursing. This meeting is attended by the Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Worker, Director of Rehabilitation, and the Administrator. Residents exhibiting changes are reviewed by the team so that any necessary modifications can be made to the resident's care plan. Changes would include residents exhibiting pacing and/or exit-seeking behaviors. As is customary, physician support will be enlisted by the facility Director of Nursing and/or Assistant Director of Nursing upon notification of the need for a medical examination and request for individual treatment that may be deemed necessary resident needs.

The Director of Nursing, Assistant Director of Nursing and Nurse Managers reviewed the residents at risk for Elopement with the direct care staff. Inservices began on 2-20-24 with the Certified Nursing Assistants, Licensed and Registered Nurses. Documentation expectations and how to manage resident behaviors was

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included in the education on Elopement Prevention and the facility policy and procedures. This information is presented to all new hires and is included on a onboarding check off list to document completion of the education provided on documenting any at risk behaviors of residents. This task is managed by the Human Resource Director.

4-30-2024 Immediate Jeopardy Removal

On 5/6/24 and 5/7/24, the plan for immediate jeopardy removal effective 4/30/24 was validated by the following: Interviews with Nursing Staff revealed they had received in-service training on Code Adam and the facility's elopement protocols along with education on the facility's alarm system referred to as "screamers." Return verbal demonstrations of the procedures were provided by staff in the facility. Spot risk elopement assessments were reviewed for a sample of residents which revealed the facility had assessed the residents for current risk factors for the residents.

3. Resident #6 was admitted to the facility on 11/15/19 with diagnoses including alcoholic cirrhosis and depression.

The care plan for drug abuse initiated on 07/28/22 revealed Resident #6 had a potential or actual drug abuse related to the history of drug abuse. The goal was to remain free of signs and symptoms of drug abuse through the next review date. Interventions included monitoring for signs and symptoms of drug abuse and performing random drug screening as needed.

The care area assessment dated 05/19/23

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revealed Resident #6 had a history of drug and alcohol abuse.

The quarterly Minimum Data Set (MDS) dated 03/29/24 coded Resident #6 with an intact cognition. He had adequate vision and hearing and clear speech. The MDS indicated Resident #6 was independent for all activities of daily living and able to ambulate without a mobility device.

A review of the visitor logs and the medical records revealed Resident #6 did not have any visitors or was on leave and absent from 01/01/24 through 04/23/24.

The nurse's progress notes dated 04/06/24 revealed Resident #6 was found to have slurred speech and unable to sit, stand, or keep his eyes opened at around 8:45 PM. He could not answer questions from the staff but was making the comment, "I feel good and high". Nurse #2 notified the on-call provider and received orders to assist Resident #6 back to the bed and monitor his vital signs closely. Around 9:00 PM, a urine specimen was obtained per the on-call provider's order for a drug screening. At approximately 10:00 PM, Resident #6's speech remained slurred and could not take the scheduled bedtime medications. At 11:00 PM, Resident #6's vital signs remained stable but still unable to keep his eyes opened. On 04/07/24 at 1:30 AM, the results from the urine drug screening were obtained and faxed to the on-call provider.

The vital signs documented on 04/06/24 at 11:15 PM revealed Resident #6's blood pressure was 98/52 millimeters mercury (mm Hg), pulse rate 60 times per minute, body temperature 96.4 Fahrenheit, and respiratory rate 16 times per

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minute.

A review of medical records indicated Resident #6 had a 12-Panel urine drug screening conducted on 04/06/24 and was positive for THC.

A review of medication administration records (MARs) from 01/01/24 through 04/23/24 revealed Resident #6 was not ordered to receive any medications containing THC.

During an interview conducted on 04/23/24 at 3:30 PM, Resident #6 stated he would not take drugs from anyone except nurses in the facility. He attributed the incident to the medications he received from nurses in the facility prior to the incident. He explained he did not have any friends or families who visited him prior to the incident and added he never received any illegal substances from anyone in the facility.

A phone interview was conducted with Nurse #2 on 04/23/24 at 4:15 PM. She stated she worked second shift from 7 PM to 7 AM on 04/06/24 evening and was providing care for Resident #6 in 300 Hall. At around 8:45 PM, Resident #6 was brought to her by a staff member from the rehab department with altered mental status, impaired movements, and slurred speech. She contacted the on-call provider immediately and was told to monitor Resident #6's vital signs and collect urine specimen for a drug screening. After obtaining Resident #6's urine specimen, she ordered one of her nurse aides (NA) to bring it to the local hospital immediately and waited for the results. Resident #6 tried to stand up at around 10 PM and was noted to be very unsteady. He was assisted back to the bed, instructed to remain in the bed, and call for help if he needed to get up.

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At around 1:30 AM, the results from the urine drug screening confirmed Resident #6 was positive for THC. She faxed the results to the on-call provider immediately and was ordered to report the results to the Director of Nursing (DON). She stated Resident #6 was alert and oriented, able to ambulate independently and interact with others verbally in the facility. She did not know how Resident #6 acquired the illegal substances.

An interview was conducted with the Assistant Director of Nursing (ADON) on 04/24/24 at 8:43 AM. She recalled Nurse #2 called her on 04/06/24 evening regarding Resident #6's altered mental status. She advised Nurse #2 to consult the on-call provider. Then Nurse #2 called her back stating that the on-call provider did not want her to send Resident #6 to emergency room (ER) as his vital signs were within the normal limits and breathing was unlabored. Instead, the on-call provider ordered to conduct a 12-Panel drug screening and continued to monitor vital signs and breathing closely. Since she was only 5 minutes from the facility, she decided to come to the facility to assist Nurse #2. When she arrived at the facility around 9 PM, Resident #6 tried to stand up in his room but was unsteady, and he appeared to be very sedated. Resident #6 was assisted to the bed and instructed not to get up without asking for help. She left the facility about 2 hours later. She did not know how Resident #6 obtained the illegal substances as he rarely had any visitors or had been absent from the facility in recent months.

During a phone interview conducted on 04/24/24 at 9:14 AM, NA #3 stated she worked on 04/06/24 from 7 PM to 7 AM in 300/400 Halls. She recalled

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when she took Resident #6 to the bathroom before putting him to bed at approximately 9 PM, he was very confused. He looked at the cup and said he was going to fill it up. After obtaining Resident #6's urine specimen, Nurse #2 wanted her to take it to the local hospital as the facility's lab did not run on weekends. She took the urine specimen to the hospital's lab and waited in the hospital. Then she brought the results back to the facility.

An attempt to conduct a phone interview with the on-call provider on 04/24/24 at 9:33 AM was unsuccessful. She did not return the call.

During an interview conducted on 04/24/24 at 10:30 AM, Resident #6's Guardian stated Resident #6 had a history of using marijuana and denied hearing Resident #6 had any substance abuse reported in the past one year. He added Resident #6 enjoyed the monthly shopping trips and the outings were under tight supervision. He felt that the facility had failed to protect Resident #6 from obtaining illegal substances to avoid harm or injury.

A joint interview was conducted on 04/24/24 at 10:41 AM with Resident #6 and the Guardian. Resident #6 insisted that he did not receive any illegal substances from anyone inside or outside of the facility. He explained he obtained the last batch of vapes over one month ago and suspected the vapes he used prior to the incident could have been contaminated.

During an interview conducted on 04/24/24 at 11:52 AM, UM #2 stated she searched Resident #6's room with another nurse on 04/07/24 morning for illegal substance with his permission,

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and the result was unremarkable. She stated Resident #6 did not have any visitors in the past few months except the supervised shopping trips that occurred once per month. She did not know how he obtained the illegal substance so far.

An interview was conducted with the DON on 04/24/24 at 12:54 PM. She stated the staff in the activity department kept all the smoking and vape supplies for the residents. She denied hearing any report indicating vapes used by residents in the facility were contaminated with marijuana so far. The monthly shopping outings normally consisted of 5-6 residents and were supervised by the driver and 1 staff member. They went to the local Walmart and remained in the store until all the residents left together. She did not know how Resident #6 gained access to the illegal substances. It was her expectation for the facility to remain free of illegal substances all the time.

During an interview conducted on 04/24/24 at 1:39 PM, the Activity Assistant stated he was familiar with Resident #6 and recalled he supervised Resident #6's vaping on 04/06/24 around 4:15 PM. He denied Resident #6 had smoked any vapes contaminated with marijuana that afternoon. Otherwise, he could have noticed the distinctive odor. All the vape pens and cartridges were kept in a locked compartment in the activity department. He did not know how Resident #6 obtained the illegal substances and stated the activity department had been free of illegal substances so far.

An interview was conducted with the MD on 04/24/24 at 1:53 PM. He stated he was being notified of the incident on 04/07/24 in the morning. Despite having a history of substance

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F 689	Continued From page 119 abuse, this was the first time Resident #6 tested positive for THC in the facility. The MD stated he had ordered a room search in March when Resident #6 was suspected of smoking marijuana. However, the search was unremarkable. He did not know how Residents #6 obtained the illegal substances and refused to speculate how it happened. It was his expectation for the facility to remain free of illegal substances to protect residents from serious harm or injury. During an interview conducted on 04/24/24 at 3:28 PM, the Administrator stated it was her expectation for the facility to be free of illegal substances.	F 689		
F 726 SS=J	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 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	F 726		7/1/24

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F 726	Continued From page 120 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 reviews, and staff interviews, the facility failed to ensure nursing staff were trained and competent with responding to medical emergencies, activating emergency procedures with emergency medical services, and notifying medical providers for 1 of 4 residents (Resident #8) reviewed for neglect. Nursing staff failed to notify a medical provider of significant changes in a resident's condition who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction, and failed to immediately initiate emergency procedures with 911. Resident #8 expired on 3/2/24. This was for 2 of 2 staff members reviewed for competency (Nurse #20 and Nurse #14). Immediate jeopardy began on 3/2/24 when nursing staff did not demonstrate competency in responding to a medical emergency. The immediate jeopardy was removed on 5/17/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education	F 726	F726 Competent Nursing Staff Immediate action taken to address this alleged deficiency: Resident #8 was discharged from the facility on 3/2/24. All residents have the potential to be affected by the alleged deficient practice of failing to activate the emergency medical response (EMS) for symptoms of drug overdose . Measures put into place to ensure that this alleged deficient practice does not recur includes: Nurse #20, an agency no longer works in the facility as of 5/13/24. Nurse #14 has received education on the Narcan Policy, primary care physician (PCP) notification and activation of the emergency response on 5/11/24. The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24. Licensed	

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and ensure monitoring systems put into place are effective for ensuring all staff are trained and competent before caring for residents in the facility.

The findings included:

A review of the employee file for Nurse #20 indicated verification of an active license to practice in the state, and a checklist entitled, "Agency Staff Facility Orientation." The checklist was initialed and signed by Nurse #20 on 3/2/24. Included in the checklist were emergency codes, Narcan, and code blue.

A review of the employee file for Nurse #14 indicated she was hired on 8/20/19 as a charge nurse. A new-hire orientation checklist was completed on 8/20/19 and verification of an active license to practice in the state was done. The checklist dated 8/20/19 indicated Nurse #14 was checked off on the location of fire alarms, location and operation of emergency exits, location of fire extinguishers, fire plan, evacuation procedure, emergency telephone numbers, door alarms, and emergency generators. The "Nurse Supervisor" job description was signed by Nurse #14 and the Director of Nursing on 3/15/24. Included in the job description were to assist the charge nurse in monitoring seriously ill patients, and to notify the attending physician and next-of-kin when there is a change in the resident's condition.

A progress note dated 3/2/24 at 9:36 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 was given Narcan per order. Oxygen saturation 68% (normal value 95% or higher), resident not responding to painful stimuli, pupils constricted. (Small pupils or

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nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed.
Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose prior to working their first shift by the DNS/Assistant Director of Nursing (designee).
A facility look-back audit of 30-days was completed to ensure any resident that was administered Narcan, the medical provider was notified, and activation of emergency response was completed by Nurse Consultant on 5/10/24, no other issues were noted.
The facility will continue with conducting "Mock Medical Emergency Drills" on each shift weekly x 4 weeks, and then ongoing monthly x3 months. The Director of Nursing and /or nursing supervisory staff will critique the drills denotin areas of improvement .

The system the facility has implemented is the Director of Nursing and /or nursing supervisory staff will perform a documented audit of the 24 hour report on a daily basis for appropriately responding to medical emergencies, activation of emergency medical response,(EMS), and notifying the medical provider of significant changes in a resident's condition. Feedback will be provided by the Director of Nursing to the licensed nurse addressing any challenges or barriers in the use of Narcan and/or activation of the emergency response and

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constricted pupils are common symptoms of opioid overdose.) Narcan given in nostril. Resident now 95% on oxygen. Blood pressure 128/72 (normal value less than 120/80), heart rate 84 (normal value 60 to 100 beats per minute), respirations 18 (normal value 12 to 18 breaths per minute) and regular.

Another progress note dated 3/2/24 at 9:47 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 now resting with eyes closed. Oxygen saturation 98%. No signs/symptoms of pain or shortness of breath.

A progress note dated 3/2/24 at 10:00 AM by Agency Nurse #20 in Resident #8's medical record indicated: Resident #8 was sitting up in wheelchair, very difficult to arouse. Oxygen saturation was 71% on oxygen via nasal cannula. Resident #8 was placed back to bed with head of bed elevated. Somewhat more responsive but continued to nod off. Oxygen saturation increased to the low 80% with deep breaths. Narcan administered by Nurse #14. Narcan somewhat effective, more alert and verbal. Morning medications held.

A second progress note dated 3/2/24 at 12:58 PM by Nurse #20 in Resident #8's medical record indicated: Resident #8 difficult to arouse at this time. Responds to sternal rub (application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) with mumbles. Oxygen on per order via nasal cannula. BiPAP (bilevel positive airway pressure which is a form of non-invasive ventilation therapy used to help you breathe) placed on. More verbal and alert at this time.

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notification to the medical provider.
The results of the 24-hour report review will be presented by the Director of Nursing to the QAPI Committee monthly for 3 months or until the committee determines compliance.

Completion Date: 7-1-2024

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A phone interview with Nurse #20 on 5/7/24 at 12:52 PM revealed she took care of Resident #8 on the day he died. Nurse #20 stated Resident #8 was not alert and was unresponsive, so she got Nurse #14 to come in his room to see him and they took his vital signs which were the same vital signs recorded by Nurse #14 in her 9:36 AM progress note. Nurse #20 stated that Resident #8's oxygen saturation level was very low. She could not recall the exact numbers, but she remembered it being in the 70s. Nurse #20 said that Nurse #14 administered Narcan to Resident #20. Nurse #20 further stated she was not sure why EMS (Emergency Medical Services) was not notified, and she did not know at the time that EMS was supposed to be notified when Narcan was administered. Nurse #20 shared that she did not look at the order for Narcan because she was not the one who administered it to Resident #8. Nurse #20 recalled Resident #8's pupils being very pinpoint, and he was very lethargic on the day that he died but because Nurse #14 told her that Resident #8 was DNR (Do Not Resuscitate) and that there was nothing else they could do for him, she did not think about calling EMS. Nurse #20 stated she was not familiar with Narcan and had never given it before. She also did not receive training on Narcan administration at the facility prior to her working there.

A follow-up phone interview with Nurse #20 on 5/8/24 at 12:26 PM revealed that 3/2/24 was her very first day working at the facility as an agency nurse and she did not have access at the time to the clinical messaging platform that the facility used to contact the on-call providers. Nurse #20 stated that she did not think about calling the on-call provider because she thought that Nurse

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F 726	Continued From page 124 #14 took over Resident #8's care when she gave him the Narcan. Nurse #20 explained that during this incident, she was still trying to get her medication pass done, and she thought Nurse #14 was going to take care of Resident #8. Nurse #20 further shared that she asked Nurse #14 if they needed to send Resident #8 to the hospital, but Nurse #14 told her no, and that they were not going to do anything for Resident #8 because he was DNR. Nurse #20 confirmed that Resident #8 was somewhat more responsive after the two doses of Narcan, but she was not familiar with him because this was her first time taking care of Resident #8, so she did not know what was normal for him. Resident #8 stayed in bed asleep, and his oxygen saturation went up a little, but he got worse in the afternoon when he became lethargic and unresponsive with no heart rate and no breathing. She notified Nurse #14 but again Nurse #14 told her there was nothing they could do for Resident #8. Nurse #20 stated she could not remember why she did not send Resident #8 to the hospital after he received the two doses of Narcan. She did not think of administering the Narcan again and did not think about calling 911. She further shared that she had never administered Narcan before which was why she asked for help from Nurse #14. The interview further revealed that Nurse #20 started as an agency nurse on 3/2/24 and later signed a contract with the facility. Nurse #20 stated she received no orientation prior to working at the facility because agency staff did not receive orientation. Nurse #20 stated that she was only given an orientation packet and was asked to sign a checklist, but she did not have time to read over the material before she started working on the floor on 3/2/24. Nurse #20 also stated she was not familiar with the facility's policy regarding	F 726		

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the administration of Narcan. She further stated that she was not sure how to notify an on-call provider for the facility if needed during a medical emergency. Nurse #20 explained that she did not receive any training from the facility regarding emergency procedures.

A phone interview with Nurse #14 on 5/8/24 at 10:56 AM revealed she was working as the weekend supervisor on 3/2/24 when Nurse #20 alerted her about Resident #8 being unresponsive. Nurse #14 stated that she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications. Nurse #14 said she thought Nurse #20 spoke with the on-call provider while she was busy taking care of Resident #8. Nurse #14 further stated that Nurse #20 told her that she had called the doctor, and she thought that Nurse #20 had also called 911. Nurse #14 commented that she thought Nurse #20 had called 911 because Resident #8 was Nurse #20's resident, and after giving Resident #8 the two doses of Narcan, Nurse #14 went back to the other side of the building. Nurse #14 stated that she knew this was Nurse #20's first day working at the facility, and that she was supposed to monitor Nurse #20, but she was also busy on another hall. Nurse #14 stated she did not think she needed to call 911 because Resident #8 responded to the Narcan doses, and he was DNR. Nurse #14 further stated that she was not familiar with the facility's policy for Narcan administration, and had not received training on how to administer Narcan. She found out later around 2:00 PM that Resident #8 took a turn for the worse but because the Assistant Director of Nursing (ADON) told her that morning after she gave him Narcan that

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Resident #8 was DNR, and that he was dying, she didn't think there was anything else she should have done.

During a follow-up interview with Nurse #14 on 5/10/24 at 8:32 AM, Nurse #14 stated she started as the weekend supervisor on 2/26/24, but she did not get orientation on her job responsibilities. Nurse #14 stated she remembered signing a job description, but she did not receive formal training on what she needed to do as the weekend supervisor. Nurse #14 also stated that she was the nurse who had been at the facility the longest and she had worked previously as a supervisor nine years ago.

A joint interview with the Director of Nursing (DON) and the ADON on 5/10/24 at 2:34 PM revealed agency nurses who worked per diem received an orientation packet while agency nurses who signed a contract with the facility received at least one shift of orientation while working with another nurse. The DON stated Nurse #20 started as a per diem agency nurse so she would not have gotten a shift orientation before she worked on the floor. The Human Resources Director usually reviewed the packet with agency nurses prior to them working, but Nurse #14 should have monitored Nurse #20 since it was her first day working at the facility, and it was on a weekend. The ADON further stated that Nurse #14 did not get training as a supervisor, and they were not sure whether she used to be supervisor. The DON stated Nurse #14 was expected to read her job description and that they went over her responsibilities with her as a team.

An interview with the Administrator on 5/10/24 at

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4:34 PM revealed they put agency nurses through an onboarding list. Nursing went over with them the review of the medication carts. The Administrator stated that typically when agency nurses started, they came in with the knowledge on how to do their job while receiving monitoring from administrative staff. Nurse #14 had worked as a charge nurse, as a Unit Manager, and as the Director of Nursing before at the facility.

The Administrator was notified of immediate jeopardy on 5/16/24 at 10:54 AM.

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:

The facility failed to ensure nursing staff were trained and competent in responding to medical emergencies, activating emergency response, and notifying medical providers for Resident #8 who received two doses of Narcan on 3/2/24 at 9:34 AM and 9:54 AM, with positive response, for suspicion of drug overdose.

All residents who use opioid medications are at risk of overdose and may be subject to the need for Narcan administration and emergency response.

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.

The facility needs to have a system in place to

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provide training and verify competencies for nurses related to responding to medical emergencies, medical provider notification and activation of emergency response.
The facility continues to employ agency nurses without providing orientation and training prior to providing care to the residents.

* An audit was completed by 5/12/24 by the Nurse Consultant on the number of residents who are prescribed opioid medication, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids.

* The Director of Nursing/Assistant Director of Nursing (designee) has re-educated the licensed nursing staff on medical emergencies and emergency activation response per physician orders on 5/11/24.

* The actions the Director of Nursing/ Assistant Director of Nursing (designee) will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers, which can require re-education if needed.

* Agency licensed nurses working at the facility will receive education on medical emergencies and activation of the emergency response by the DNS/Assistant Director of Nursing (designee).

* Licensed nursing staff, including agency staff that are not available on or before 5/11/24 will not

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VERO HEALTH & REHAB OF SYLVA	**417 CLOVERDALE ROAD** **SYLVA, NC 28779**

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F 726	Continued From page 129	F 726		

be scheduled until the education has been completed. The Director of Nursing/Assistant Director of Nursing (designee) will provide education on medical emergencies, medical provider notification, and activation of emergency response for the nursing staff unavailable after 5/11/24 before they start the shift.

* The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system which is denoted in the revised Narcan Administration Policy 5/10/24.

* The facility will initiate "Mock Medical Emergencies Drills" on each shift weekly x 4 weeks, and then ongoing monthly upon completion of the licensed nursing education. The first drill took place 5/14/24. The DNS and/or the ADNS will critique the drill denoting areas in need of improvement.

The alleged date of immediate jeopardy removal is 5/17/24.

The credible allegation for the immediate jeopardy removal was validated on 5/22/24 with a removal date of 5/17/24.

A review of in-service education records dated 5/11/24 revealed education was provided to nurses including agency nurses on the activation of emergency response upon administration of Narcan, and ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with the nursing staff including agency nurses revealed they had been educated on activating EMS and notifying the medical provider

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F 726	Continued From page 130 of any resident who receives Narcan for suspected overdose. The nurses including agency nurses stated they received education on medical emergencies and activation of the emergency response. Interviews with staff confirmed a mock medical emergency drill was conducted on 5/14/24 and 5/15/24 where the nursing staff initiated emergency response and notified the doctor of a suspected drug overdose. The audit completed by the Nurse Consultant on 5/12/24 was reviewed. All residents identified as having orders for Narcan administration had notification of medical providers added to the Narcan order. A review of the revised policy for Narcan Administration dated 5/10/24 indicated that the nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system. The facility's date of immediate jeopardy removal of 5/17/24 was validated.	F 726		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records 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(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		7/1/24

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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 record reviews, staff, family, Pharmacist and Medical Director interviews the facility failed to obtain an antianxiety medication from the pharmacy which caused a resident to miss 3 doses of antianxiety medication for 1 of 5 residents (Resident #7) reviewed for medication errors. This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down.

The findings included:

Resident #7 was admitted to the facility on 06/22/22 with diagnoses including anxiety disorder.

F 755

F755 Pharmacy Services

The immediate action taken to address this alleged deficient practice includes: The facility obtained the lorazepam 1mg from the pharmacy on 4-26-2024 for Resident#7. Education was provided to the Director of Nursing and the Assistant Director of Nursing on the process in securing controlled substances from the designated back up pharmacy when necessary.

The facility recognizes that any resident receiving scheduled lorazepam has the potential to be affected by this alleged deficient practice.

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Review of Resident #7's physician orders revealed an order dated 04/30/23 for lorazepam one milligram (mg) every twelve hours as needed for anxiety and an order dated 05/01/23 for lorazepam one mg by mouth three times a day for anxiety.

The quarterly Minimum Data Set (MDS) assessment dated 03/19/24 revealed Resident #7 was cognitively intact, had unclear speech, was usually able to make himself understood, and was able to understand others. The MDS also indicated Resident #7 received antianxiety medication during the lookback period.

Resident #7's Medication Administration Record (MAR) for April 2024 revealed the doses of lorazepam one mg scheduled for 8:00 AM, 2:00 PM, and 9:00 PM on 04/25/24 were not initialed as administered.

An interview with Nurse #17 on 05/08/24 at 1:58 PM revealed she was assigned to care for Resident #7 on 04/25/24 on the 7:00 AM to 11:00 PM shift and was notified in report the morning of 04/25/24 that Resident #7 was out of his scheduled lorazepam 1 mg. Nurse #17 stated Resident #7 had a physician order for prn (meaning as needed) lorazepam one mg every twelve hours, but he was out of that medication also and there was none in the emergency back-up medication dispenser. Nurse #17 explained when she completed her 8:00 AM medication pass, she called pharmacy to ask when Resident #17's lorazepam would be available and was told Resident #17 needed a new prescription for the medication. She stated she notified the ADON and DON that Resident #17 was out of lorazepam one mg, had missed

F 755

Measures put into place dot ensure that his alleged deficient practice includes the following:
A 2-week look back audit was completed by the nurse consultant to ensure that scheduled doses of lorazepam have been administered. This audit was completed on 6-7-2024. This was completed by the Clinical Nurse Consultant.
Licensed nurses will complete re-education by 6-19-2024 on ensuring that lorazepam is reordered from the pharmacy on a timely basis by the Director of Nursing and/or Nursing Supervisors.

Monitoring will be completed by the DNS/designee will conduct an audit weekly ensuring that all lorazepam is ordered timely, and no resident has missed any lorazepam doses. The results of the audits will be presented by the Director of Nursing to the QAPI Committee monthly for 3 months or until the committee determines compliance.

Completion Date: 7-1-2024

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two scheduled doses of lorazepam on 04/25/24, and needed a new prescription to be sent to the pharmacy. Nurse #17 stated she was notified by the ADON that Resident #17's lorazepam would arrive from the pharmacy in the night delivery. She stated the lorazepam did not arrive from pharmacy before she left the night of 04/25/24.

An interview with NA #7 on 05/10/24 at 8:10 AM revealed she cared for Resident #7 on 04/25/24 on the 7:00 AM to 7:00 PM shift. She stated Resident #7 did not receive his lorazepam that day and was anxious all day. NA #7 explained Resident #7 repeatedly rang his call light to request his lorazepam, was sweating and shaking, and requested she text his mom and ask her to come to the facility on 04/25/24. She stated she texted Resident #7's mom as he requested and tried to reassure Resident #7 that Nurse #17 was working on getting his medication throughout her shift.

A telephone interview with Resident #7's mother on 05/06/24 at 11:02 AM revealed 2 nurse aides (NAs) called her on 04/25/24 from Resident #7's cell phone per his request (she was unsure of the exact time of the call) because he had not received his lorazepam. She stated the NAs informed her Resident #7 was in a panic and he wanted her to come to the facility to help him calm down. Resident #7's mother stated she came to the facility to check on Resident #7 and he was "panicky" and did not want her to leave. She stated she spoke with Nurse #17 on 04/25/24 and the nurse confirmed Resident #7 was out of lorazepam and she was trying to get the medication from pharmacy. Resident #7's mother stated she later found out Resident #7 did not receive any doses of lorazepam on 04/25/24.

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A telephone interview with the Medical Director on 05/07/24 at 3:06 PM revealed when residents ran out of medication, the on-call Nurse Practitioner (NP) was notified of the need for a prescription refill and a temporary prescription was issued until the regular delivery shipment of medications was received from the pharmacy. He stated he was not notified Resident #7 missed 3 scheduled doses of lorazepam on 04/25/24 and confirmed missing the medication doses would result in an increase in anxiety.

A joint interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 05/08/24 at 1:12 PM revealed Nurse #17 notified the ADON on 04/25/24 that Resident #7 was out of his scheduled lorazepam and needed a new prescription. The ADON explained she logged onto the online forum the facility used to communicate with providers and saw multiple prescription refill requests for Resident #7's lorazepam had been requested and the providers responded that the prescription had been sent to pharmacy electronically. The ADON stated she called the pharmacy and asked for Resident #7's lorazepam to be sent to the facility stat (immediately) and she understood the medication would arrive as soon as possible. The ADON stated stat orders did not mean the same thing in long term care as in acute care, but she thought the medication would arrive sooner than the scheduled pharmacy delivery that occurred nightly between 10:30 PM and midnight. When the ADON and DON were asked why they did not request a prescription be sent electronically by the provider to a local pharmacy and picked up on 04/25/24, they explained they were new to their roles and did not know that was an option.

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F 755	Continued From page 135 They stated in hindsight, they would have asked the provider to send an electronic prescription for the lorazepam to a local pharmacy and staff would pick it up rather than waiting on the medication to arrive from the facility pharmacy located in Hickory, NC. An interview with the Pharmacist on 05/08/24 at 5:18 PM revealed the last refill request from the facility for lorazepam one mg for Resident #7 prior to 04/25/24 was on 03/15/24. She stated on 03/17/24 sixty lorazepam one mg tablets were delivered to the facility for Resident #7. The Pharmacist confirmed she had no record of a stat request for lorazepam tablets from the facility on 04/25/24 for Resident #7. An interview with the Administrator on 05/10/24 at 4:15 PM revealed it was her understanding that nursing staff had a difficult time getting Resident #7's prescription refilled for lorazepam and when the prescription was obtained and sent to pharmacy, the medication did not arrive in the pharmacy delivery (she could not recall the date). She confirmed Resident #7 missed 3 scheduled doses of lorazepam on the day in question. The Administrator stated in hindsight the Medical Director should have been contacted and a prescription for lorazepam called in to a local pharmacy and picked up, so the resident did not have to miss multiple doses of scheduled medication.	F 755		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		7/1/24

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F 760	Continued From page 136 This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director, and family interviews the facility failed to ensure a resident was free of significant medication errors due to failing to administer three scheduled lorazepam (antianxiety medication) doses. The deficient practice was for 1 of 5 residents reviewed for medication errors (Resident #7). This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down. The findings included: Resident #7 was admitted to the facility on 06/22/22 with diagnoses including anxiety disorder. Review of Resident #7's physician orders revealed an order dated 04/30/23 for lorazepam one milligram (mg) every twelve hours as needed for anxiety and an order dated 05/01/23 for lorazepam one mg by mouth three times a day for anxiety. The quarterly Minimum Data Set (MDS) assessment dated 03/19/24 revealed Resident #7 was cognitively intact, had unclear speech, was usually able to make himself understood, and was able to understand others. Resident #7's care plan last updated 03/19/24 revealed he used antianxiety medications related to anxiety disorder. Interventions included administering antianxiety medications as ordered by the physician, and monitoring/recording the occurrence of target symptoms.	F 760	Disclaimer notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal Regulations. F760 Med Errors Immediate action taken to address this alleged deficient practice includes: The lorazepam 1mg was delivered from the pharmacy for Resident#7 on 4-26-2024. A 2-week look back audit was completed by the nurse consultant to ensure that scheduled doses of lorazepam have been administered on 6/7/24. The Director of Nursing/Designee will provide education and oversight on medication ordering and obtaining hard scripts. This education will be provided to all clinical nursing staff by 6-19-2024. The licensed nurses will have also receive education and re-education on the process to ensure that lorazepam is reordered from the pharmacy on a timely basis. This education will be provided by the Director of Nursing and /or Nursing Supervisors. Monitoring will be completed by : The DNS will conduct an audit three times weekly by a review of the Electronic Medical Record, (EMAR) ensuring that all lorazepam is ordered timely, and no resident has missed any lorazepam doses. This audit will be reviewed for 3 months and a report will be compiled by the Director of Nursing and presented to	

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Resident #7's Medication Administration Record (MAR) for April 2024 revealed the doses of lorazepam one mg scheduled for 8:00 AM, 2:00 PM, and 9:00 PM on 04/25/24 were not initialed as administered.

An interview with Nurse #17 on 05/08/24 at 1:58 PM revealed she was assigned to care for Resident #7 on 04/25/24 on the 7:00 AM to 11:00 PM shift and was notified in report the morning of 04/25/24 that Resident #7 was out of his scheduled lorazepam 1 mg. Nurse #17 stated Resident #7 had a physician order for prn (meaning as needed) lorazepam one mg every twelve hours, but he was out of that medication also and there was none in the emergency back-up medication dispenser. Nurse #17 explained when she completed her 8:00 AM medication pass, she called pharmacy to ask when Resident #17's lorazepam would be available and was told Resident #17 needed a new prescription for the medication. She stated she notified the ADON and DON that Resident #17 was out of lorazepam one mg, had missed two scheduled doses of lorazepam on 04/25/24, and needed a new prescription to be sent to the pharmacy. Nurse #17 stated she was notified by the ADON that Resident #17's lorazepam would arrive from the pharmacy in the night delivery. She stated the lorazepam did not arrive from pharmacy before she left the night of 04/25/24. Nurse #17 confirmed Resident #7 was tense all day on 04/25/24, had episodes of crying throughout the day, repeatedly requested his lorazepam, and asked Nurse Aide (NA) #7 to call his mom multiple times throughout the day. She stated she reassured Resident #7 throughout her shift that she was working on obtaining the

Provider's plan of correction (F 760):

the Quality Assurance Committee monthly for 3 months or until a pattern of compliance is established.

Completion Date: 7-01-2024

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medication from pharmacy.

An interview with NA #7 on 05/10/24 at 8:10 AM revealed she cared for Resident #7 on 04/25/24 on the 7:00 AM to 7:00 PM shift. She stated Resident #7 did not receive his lorazepam that day and was anxious all day. NA #7 explained Resident #7 repeatedly rang his call light to request his lorazepam, was sweating and shaking, and requested she text his mom and ask her to come to the facility on 04/25/24. She stated she texted Resident #7's mom as he requested and tried to reassure Resident #7 that Nurse #17 was working on getting his medication throughout her shift.

A telephone interview with Resident #7's mother on 05/06/24 at 11:02 AM revealed 2 nurse aides (NAs) called her on 04/25/24 from Resident #7's cell phone per his request (she was unsure of the exact time of the call) because he had not received his lorazepam. She stated the NAs informed her Resident #7 was in a panic and he wanted her to come to the facility to help him calm down. Resident #7's mother stated she came to the facility to check on Resident #7 and he was "panicky" and did not want her to leave. She stated she spoke with Nurse #17 on 04/25/24 and the nurse confirmed Resident #7 was out of lorazepam and she was trying to get the medication from pharmacy. Resident #7's mother stated she later found out Resident #7 did not receive any doses of lorazepam on 04/25/24.

A telephone interview with the Medical Director on 05/07/24 at 3:06 PM revealed when residents ran out of medication, the on-call Nurse Practitioner (NP) was notified of the need for a prescription refill and a temporary prescription was issued

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F 760	Continued From page 139 until the regular delivery shipment of medications was received from the pharmacy. He stated he was not notified Resident #7 missed 3 scheduled doses of lorazepam on 04/25/24 and confirmed that would be a significant medication error for Resident #7 and would result in an increase in anxiety. A joint interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 05/08/24 at 1:12 PM revealed Nurse #17 notified the ADON on 04/25/24 that Resident #7 was out of his scheduled lorazepam and needed a new prescription. They stated in hindsight, they would have asked the provider to send an electronic prescription for the lorazepam to a local pharmacy and staff would pick it up rather than waiting on the medication to arrive from the facility pharmacy located in Hickory, NC. An interview with the Administrator on 05/10/24 at 4:15 PM revealed it was her understanding that nursing staff had a difficult time getting Resident #7's prescription refilled for lorazepam and when the prescription was obtained and sent to pharmacy, the medication did not arrive in the pharmacy delivery (she could not recall the date). She confirmed Resident #7 missed 3 scheduled doses of lorazepam on the day in question. The Administrator stated in hindsight the Medical Director should have been contacted and a prescription for lorazepam called in to a local pharmacy and picked up, so the resident did not have to miss multiple doses of scheduled medication.	F 760		
F 841 SS=E	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2)	F 841		7/1/24

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§483.70(h) Medical director.
§483.70(h)(1) The facility must designate a physician to serve as medical director.

§483.70(h)(2) The medical director is responsible for-
(i) Implementation of resident care policies; and
(ii) The coordination of medical care in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews with staff and the Medical Director (MD), the facility failed ensure the MD was aware of resident care policies related to the administration of Naloxone or Narcan (a medication designed to rapidly reverse opioid overdose in an emergency situation). This deficient practice had the potential to affect all residents with active orders for Narcan.

The findings included:

A review of the Medical Director/Attending Physician job description signed by the facility's Medical Director (MD) on 2/1/24 included the following under essential functions and responsibilities: Medical directorship functions include attending and participating in monthly quality assurance and process improvement meetings, participating in quality improvement initiatives, providing guidance to facility staff, overseeing clinical care plan, reviewing and revising (if necessary) facility's clinical guidelines, insuring compliance with state and federal regulations, training facility staff, and supervising facility clinical staff.

An interview with the Medical Director (MD) on 5/8/24 at 10:21 AM revealed he started working

F 841

F841 Medical Director Responsibilities

Immediate action taken to address this alleged deficient practice include: The Medical Director received a review of the Policy and Procedure for the Administration of Narcan by the Regional Clinical Consultant on 5-29-2024. Explanations of the policy, policy modification, and the functions and responsibilities of the Medical Director was reviewed with the Clinical Consultant and the contract Clinical Representative on 5-30-2024. An attestation was obtained with the Medical Director's signature on 5-30-2024.

All residents have the potential to be affected by this alleged deficient practice.

Measures put into place to ensure that this alleged deficient practices does not recur includes. Education was provided to the Medical Director on the responsibilities for the directorship of a long-term care facility assignment. Quality Assurance responsibilities, policy and procedure review, clinical practice oversight and clinical rounding and oversight of resident

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F 841	Continued From page 141 at the facility as the Medical Director in February 2024. The MD stated that he was not familiar with the facility policy for Narcan. The MD stated that if the policy indicated for staff to notify Emergency Medical Services when administering Narcan, then the staff should have followed the policy. An interview with the Administrator on 5/22/24 at 4:35 PM revealed the current MD took over in mid-January 2024, and he had attended the QA (Quality Assurance) meetings, but he had not been to all of them. The Administrator stated that they discussed random facility policies during the QA meetings. She stated that she did not know that the MD did not know about the facility's Narcan policy, but she knew that he had just been notified of the updated Narcan policy after they discussed the issues identified during the current survey.	F 841	care delivery. Monitoring will be accomplished by the Medical Director completing weekly visits to the facility and maintaining communications with the Director of Nursing on any clinical concerns. The Director of Nursing will compile a report of any clinical policy issues and report to the Quality Assurance and Process Improvement Committee monthly for 3 months. Completion date 7-1-2024	
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.	F 867		7/1/24

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§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and 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

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level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness 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.

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§483.75(g)(2) The quality assessment and assurance committee reports to the facility's 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 observations, record reviews, an audio digital file, and interviews from resident, staff, visitor, family, Pharmacist, and Medical Director, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification surveys conducted on 4/29/21 and 1/20/23 and the complaint investigation surveys conducted on 9/29/21, 1/6/22, 6/7/23, 10/18/23, 11/21/23, 11/30/23, and 12/7/23. This was for seven repeat deficiencies that were cited in the areas of visitation rights, safe and comfortable environment, notification of changes, quality of care, accident hazards, pharmacy services and significant medication errors. Visitation rights was originally cited on 9/29/21 during a complaint investigation survey, and subsequently recited during the complaint investigation survey completed on 5/22/24. Safe and comfortable environment was originally cited on 6/7/23 during a complaint investigation survey and

F 867

Disclaimer notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal Regulations.
F684 Quality of Care

The facility held a Quality Assurance Process Improvement Committee meeting on 5-29-24. The content of the Quality Assurance Process Improvement included maintaining implemented procedures and monitoring the interventions the committee implemented following recertification surveys 4-29-21, and 1/20/2023, and for investigation surveys 9-29-21, 1-6-2022, 6-7-23, 11-21-23,11-30-2023 and 12-7-2023.

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F 867	Continued From page 145 subsequently recited during the complaint investigation survey completed on 5/22/24. Notification of changes was originally cited on 1/6/22 during a complaint investigation survey, and subsequently recited during the complaint investigation surveys completed 6/7/23 and 5/22/24. Quality of care was originally cited on 12/7/23 during a complaint investigation survey, and subsequently recited during the complaint investigation survey completed on 5/22/24. Accident hazards was originally cited on 1/20/23 during the recertification and complaint investigation survey, and subsequently recited during the complaint investigation surveys completed on 11/21/23, 11/30/23, and 5/22/24. Pharmacy services was originally cited on 4/29/21 during the recertification and complaint investigation survey, and subsequently recited during the complaint investigation surveys completed on 6/7/23, 11/30/23, and 5/22/24. Significant medication errors was originally cited on 6/7/23 during a complaint investigation survey, and subsequently recited during the complaint investigation surveys on 10/18/23, and 5/22/24. The continued failure of the facility during ten federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referred to: F563 - Based on observations, record reviews, an audio digital file, and interviews from resident, staff, and visitor interviews, the facility failed to allow unrestricted visitation by limiting visitation for 1 of 1 resident reviewed for visitation (Resident #3).	F 867	All residents have the potential to be affected by the alleged deficient practice of maintaining implemented procedures and monitoring the interventions the committee implemented. Measures put into place to prevent recurrence: The Quality Assurance and Process Improvement minutes were audited for the last 3 moths to determine the root cause analysis of maintaining implemented procedures and monitoring interventions processes. The Administrator and Department Managers were re-educated on the Quality Assurance and Process Improvement policy which included the CMS published amendment dated 6/10/2024, by the Nurse Consultant by 6-13-2024. The Nurse Consultant will attend and complete a monthly audit on ensuring that a Quality Assurance and Process Improvement is held for 3 months to ensure implemented procedures and monitoring interventions for substantial compliance. The results of the audits will be presented by the Nurse Consultant to the Quality Assurance and Process Improvement Committee monthly for 3 months or until the committee determine compliance.	

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During a complaint investigation survey on 9/29/21, the facility imposed a restricted visitation schedule that limited indoor and outdoor visitation of family and friends to 30 minutes per visit.

F580 - Based on record reviews, and interviews with resident, staff and the Medical Director, the facility failed to notify a medical provider of significant changes in a resident's condition (Resident #8) who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 suspected drug overdose and administered one dose of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on 3/2/24 at 9:34 AM and an additional dose at 9:54 AM without notifying a medical provider. Resident #8 responded temporarily to the Narcan doses but at 3:50 PM, he was observed with no heart rate or respiratory rate and was pronounced dead. In addition, the facility failed to notify the Guardian after a resident (Resident #6) tested positive for tetrahydrocannabinol (THC - a compound found in cannabis/marijuana plants). This deficient practice affected 2 of 3 residents reviewed for notification of changes.

During a complaint investigation survey on 6/7/23, the facility failed to notify the physician levetiracetam (an anticonvulsant medication) was not administered as scheduled when the resident was out of the facility.

During a complaint investigation survey on 1/6/22, the facility failed to notify a resident's representative of left shoulder x-rays that were obtained and a subsequent transfer to the

F 867

A facility look-back audit of 30-days was completed to ensure any resident that was administered Narcan, the medical provider was notified, and emergency response activated was completed by Nurse Consultant on 5/10/24.

The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by 5/11/24. Licensed nursing staff that are not available on or before 5/11/24 will not be scheduled until the education has been completed.
Agency licensed nurses working at the facility received education on the activating emergency response when administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee).
The Narcan Administration Policy was revised on 5/10/24, to include activation of EMS.
The Director of Nursing (DNS) will review the 24-hour report on a daily basis for appropriate activation of emergency medical response (EMS). Feedback will be provided by the DNS to the licensed nurse addressing any challenges or barriers in the use of Narcan and/or activation of the emergency response.
The results of the 24-hour report review will be presented by the DNS to the QAPI Committee monthly for 3 months or until the committee determines compliance.

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hospital.

F684 - Based on record reviews, and interviews with staff and the Medical Director, the facility failed to initiate emergency medical services for symptoms of a drug overdose. Resident #8 was slumped over, non-responsive with constricted pupils and impaired respiration. Resident #8 was observed by a facility staff member with no heart rate or respiratory rate and was pronounced dead on 3/2/24 at 3:50 PM. This deficient practice affected 1 of 3 residents reviewed for quality of care.

During a complaint investigation survey on 12/7/23, the facility failed to complete wound care as ordered by the wound care provider.

F689 - Based on observation, record reviews and visitor, family, staff, and Medical Director interviews, the facility failed to enforce their smoking policy, monitor a resident who had a history of non-compliance with the smoking policy for storage of smoking materials, and implement interventions to prevent a resident from vaping in his room with his oxygen on and while his roommate (Resident #6) was in the room. Resident #8, who was on oxygen, was found to have a vape pen in his possession on 2/2/24, 2/16/24, and 3/1/24, and was observed vaping while on oxygen on 3/1/24. An electronic cigarette or vape pen (vaporizer) is a device that simulates tobacco smoking. It contains a heating element which reaches high temperatures and can ignite nasal cannula with oxygen flowing. Vaping while on oxygen placed Resident #8 and Resident #6 at increased risk for fire and combustion. This posed a high likelihood of serious injury to all residents.

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The facility also failed to prevent a resident with moderate cognitive impairment, a history of wandering and exit seeking behaviors, delusional behavior, and delusions from exiting the facility unsupervised and without staff knowledge (Resident #1). Staff interviews revealed an emergency exit door alarm in hallway of the 200 unit sounded around shift change (7:00 AM) on 2/20/24 and staff disarmed the alarm without initiating a "Code Adam" (the facility elopement protocol), without conducting a full resident head count to ensure all residents were in the facility at the time, and without conducting a thorough search of the area which was accessible from the exit. Between 7:05 AM and 7:10 AM, a visitor arrived at the facility and found Resident #1 outside, unsupervised, wearing a thin night gown, holding multiple pieces of mail, without shoes, and wearing socks on her feet. The resident was discovered at the front of the facility approximately 120 yards from the 200 hall exit door. The visitor indicated Resident #1 appeared cold, so he had the resident sit in his car with the heat on until the transportation aide arrived at the facility to open the facility door around 7:30 AM. There was a high likelihood of serious injury from falls and hypothermia as temperatures were recorded at 23 degrees Fahrenheit at the approximate time Resident #1 was found outside.

In addition, the facility failed to protect a resident from exposure to an illegal substance. As a result, Resident #6 was found to have experienced altered mental status, impaired physical mobility, and slurred speech. The drug screening test conducted by Nurse #2 confirmed Resident #6 was positive for tetrahydrocannabinol (THC- a compound found in cannabis/marijuana

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plants). These deficient practices affected 3 of 5 residents reviewed for risk for accidents.

During a complaint investigation survey on 11/30/23, the facility failed to use a mechanical lift to transfer a non-ambulatory resident.

During a complaint investigation survey on 11/21/23, the facility failed to prevent a resident with severe cognitive impairment and a history of wandering and exit seeking behaviors, from exiting the facility unsupervised and without staff knowledge.

During a recertification and complaint investigation survey on 1/20/23, the facility failed to conduct smoking assessment periodically.

F755 - Based on record reviews, staff, family, Pharmacist and Medical Director interviews the facility failed to obtain an antianxiety medication from the pharmacy which caused a resident to miss 3 doses of antianxiety medication for 1 of 5 residents (Resident #7) reviewed for medication errors. This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down.

During a complaint investigation survey on 11/30/23, the facility failed to obtain a controlled pain medication from the pharmacy.

During a complaint investigation survey on 6/7/23, the facility failed to acquire medications ordered for administration resulting in multiple doses of the prescribed medication being missed.

During a recertification and complaint

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investigation survey on 4/29/21, the facility failed to have 2 nurses, or a nurse and a medication aide sign the narcotic count card.

F760 - Based on record review and staff, Medical Director, and family interviews the facility failed to ensure a resident was free of significant medication errors due to failing to administer three scheduled lorazepam (antianxiety medication) doses. The deficient practice was for 1 of 5 residents reviewed for medication errors (Resident #7). This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down.

During a complaint investigation survey on 10/18/23, the facility failed to administer a short-acting insulin as ordered by the physician.

During a complaint investigation survey on 6/7/23, the facility failed to prevent a significant medication error by not administering 12 doses of Levetiracetam (an anticonvulsant medication) as ordered by the physician.

During an interview conducted on 04/24/24 at 3:28 PM, the Administrator acknowledged that the facility had repeated citations. The Administrator stated the facility's QAPI committee had met each time after a state survey, and at least quarterly or as needed, to discuss plans of correction, implement changes, conduct training, and carry out monitoring and audit, as needed. She indicated the facility had done due diligence at its best to remain in compliance. She attributed the repeated citations to frequent changes in management staff and maintenance staff, and lack of sense of urgency by the nursing staff.

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