STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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E 000	Initial Comments The survey team entered the facility on 04/29/24 to conduct a recertification survey and a complaint investigation survey and exited on 05/03/24. Additional information was obtained on 05/07/24. Therefore, the exit date was changed to 05/07/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #N8WN11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 04/29/24 to conduct a recertification survey and a complaint investigation survey and exited on 05/03/24. Additional information was obtained on 05/07/24. Therefore, the exit date was changed to 05/07/24. Event ID# N8WN11. The following intakes were investigated NC00211035. NC00199794, NC00211180, NC00210820, NC00207692, NC00211234, NC00212783, NC00209269, NC00210159, NC00209775, NC00205184, NC00201327, NC00212030. 4 of the 36 complaint allegations resulted in deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	F 582		6/1/24

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

Electronically Signed | 05/31/2024

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F 582	Continued From page 1 (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.	F 582		

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F 582	Continued From page 2 (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS-10123 (Centers for Medicare and Medicaid Services) Notice of Medicare Non-Coverage (NOMNC) at least two days prior to discharge from Medicare part A services for 1 of 3 sampled residents (Resident #127). The findings included: Resident #127 was admitted to the facility under skilled Medicare Part A services to receive physical, occupational and speech therapy on 11/02/2023. Review of the Admission Minimum Data Set (MDS) dated 11/09/2023 indicated the resident's cognition was intact. She was dependent on staff for eating, toileting and personal hygiene. Review of the Physical Therapy discharge summary note indicated the date of services started on 11/03/2023 until 11/22/2023. Review of the Occupational Therapy discharge summary note indicated the date of services started on 11/03/2023 until 11/23/2023. A review of the medical record revealed a CMS-10123 NOMNC letter was issued, and the Responsible Party (RP) was notified on 11/28/2023 by the Business Office Manager that skilled services would be ending on 11/30/2023.	F 582	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F852 Based on record review and staff interviews, the facility failed to provide a CMS-10123 (Centers for Medicare and Medicaid Services) Notice of Medicare Non-Coverage (NOMNC) at least two days prior to discharge from Medicare part A services for 1 of 3 sampled residents (Resident #127). Corrective action for resident(s) affected by the alleged deficient practice: On May 31 2024, the Administrator/Social Worker and Admissions Director was educated by the Corporate Business Office Manager the proper procedure for of providing the CMS-10123 NOMNC at least two days prior to discharge from Medicare part A services. This was completed on May 31, 2024 1. Corrective action for residents with	

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F 582	Continued From page 3 An interview was conducted with the Social Worker (SW) on 05/02/2024 at 2:30PM SW indicated she did not have a reason for why the NOMNC was not sent out as soon as the resident was discharged from Rehab services. She added that the Business Office Manager was responsible for issuing the NOMNC letter. An interview with the Rehabilitation Director on 05/02/2023 at 11:42 AM revealed that the rehabilitation services for Resident #127 ended on 11/23/2023 and the resident did not have any other skilled services remaining. He indicated that the Business Office Manager should have provided the and NOMNC letter to the Responsible Party (RP) when the rehab services ended on 11/23/2023. An interview was conducted with the Business Office Manager on 05/02/2024 at 2:19 PM and she revealed that Resident #127's Medicare A coverage was to end on 11/23/2023 and this should have been discussed with the RP before 11/23/2023. She said that it was her responsibility to check with the family if they had filed for NOMNC appeal. The Business Office Manager added she did not know the reason the NOMNC was not sent out to RP before 11/23/2023. She indicated that she was aware that the NOMNC was to be issued 2 days prior to the end of services. The Business Office Manager indicated she notified the resident and the RP on 11/28/2023 about the NOMNC letter for Resident#127 skilled services. She indicated that The NOMNC letter was missed and was sent later which was on 11/28/2023.	F 582	the potential to be affected by the alleged deficient practice. On May 31, 2024 An audit was completed x 6 months of all resident records to identify if any other residents did not receive the CMS-10123 NOMNC at least two days prior to discharge. No deficient areas were identified. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On May 31, 2024, the facility policy and procedures were reviewed by the Corporate Business Office Manager. 0n May 31 2024, The Corporate Business Office Manager provided the education to the business manager, administrator and nursing management team emphasizing the requirement of notification of residents/RP 2 days prior to discharge form Medicare Part A services. This was completed on May 31, 2024. As of June 1, 2024, and employee who has not received this training will not be allowed to work until the training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On May 31, 2024, the facility will use the QA Nomnic Monitoring Tool to monitor residents to ensure they are provided the 2 days prior notification of the discharge of Medicare A services.	

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F 582	Continued From page 4 An interview was conducted on 05/03/2024 at 3:01 PM with the interim Administrator and she revealed it was her expectation that the residents at the facility or RP should be provided appropriate notices prior to being discharged from Medicare.	F 582	The DON or Designee will complete QA audits all residents daily x 2 weeks then monthly x 3 months or until resolved to audit for the timely completion notification of Nomnic from Medicare A services. Identified concerns will immediately be reported to the Administrator. Reports will be presented to the weekly QA committee by the Administrator to ensure corrective action is initiated as appropriate. The results of the audits will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/01/2024	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		6/1/24

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F 756	Continued From page 5 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist, and Nurse Practitioner (NP) interviews the facility failed to respond to the consultant pharmacist's recommendations for 1 out of 5 residents reviewed for unnecessary medications (Resident #42). Findings include: Resident #42 was admitted into the facility on	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	

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F 756	Continued From page 6 3/11/24 with multiple diagnoses including atrial fibrillation (an irregular rapid heart rate that commonly causes poor blood flow), gastroesophageal reflux disease, and arthritis. A review of Resident #42's admission Physician orders for March 2024 included the following: Cardizem Controlled Delivery 120 milligrams (mg) daily, enteric coated aspirin 81 mg daily, Protonix delayed release 40 mg tablet daily, Tylenol 8 hour extended release one tablet every 8 hours as needed for pain, and pentoxifylline extended release 400 mg tablet twice daily. A review of Resident #42's Pharmacy Consultant review dated 3/21/24 included the following: the electronic medical record indicates medications are crushed. Please consider the following alternatives: 1) Change Cardizem CD 120 milligram (mg) capsule daily to diltiazem 30 mg (work with cardiology for change). 2) Change aspirin enteric coated 81 mg daily to aspirin chewable 81 mg daily. 3) Change Protonix 40 mg delayed release to Protonix 40 mg granule packet daily. 4) Change Tylenol 8 hour extended release 650 mg give one tablet every 8 hours as needed for pain to Tylenol 325 mg give 2 tablets as needed for pain. 5) Evaluate pentoxifylline extended release 40 mg tab twice a day for alternative as this extended release should not be crushed. On the Pharmacy Note to the Attending Physician/Prescriber dated 3/21/24 there was a note dated 3/15/24 stating Cardizem changed to twice a day did not want to make any changes per the Nurse Practitioner. There was no other documentation in Resident #42's medical record regarding the Pharmacy Consultant review dated	F 756	deficiencies cited have been or will be corrected by the dates indicated. F756 Based on record review, staff, pharmacist, and Nurse Practitioner (NP) interviews the facility failed to respond to the consultant pharmacist's recommendations for 1 out of 5 residents reviewed for unnecessary medications (Resident #42). 1. Corrective action for resident(s) affected by the alleged deficient practice: On 05/02/ 2024 Resident #42's pharmacy recommendations were reviewed by the attending physician. Medication that could not be crushed were reviewed and new orders were transcribed into PCC. This was completed on 05/02/2024 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 05/06/2024 The Director of Nursing did an audit of the last 30 days of recommendations from the pharmacy to make sure all recommendations were reviewed and any new orders were transcribed in PCC. There were no discrepancies noted during the audit. Specific attention was paid to medication that cannot be crushed. This was completed on 05/10/2024. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 05/28/2024 the Unit Manager or Director of Nursing were educated to print the pharmacy recommendations when received. The physicians are provided the pharmacy recommendation for review and signed	

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F 756	Continued From page 7 3/21/24. An interview with the Director of Nursing on 5/2/24 at 10:00 AM stated that when she gets the Pharmacy Consultant Recommendations that she forwards them to the physician. She further stated that she does not always get them back. She further stated that she did not know who put the note on the Pharmacy Consultant review dated 3/21/24. An interview with the Nurse Practitioner on 5/2/24 at 1:55 PM revealed that she changed the Cardizem in March 2024 due to Resident #42 having increased episodes of atrial fibrillation and had an appointment with cardiology scheduled who manages Resident #42. She stated that the nursing staff usually speaks to her regarding any pharmacy recommendations and did not know why she did not address the other medications at that time. An interview with the Regional Director of Operations on 5/2/24 at 2:15 PM indicated that the physicians should be responding to the pharmacist regarding their medication regime reviews. An interview with the Pharmacy Consultant on 5/3/24 at 3:00 PM indicated that she expected the physician or their designee to respond to her recommendations and if the physician did not want to change a resident's medication that the rationale would be documented in the resident's medical record or on the communication form.	F 756	then returned to the UM to transcribe the changes and then the recommendation is signed and returned to the Director of Nursing to place in a file. This is to be completed in 24-72 hours. On 05/06/2024 the DON NOT CRUSH LIST was updated and placed on each medication cart for reference for the Medication Administrators. • The learner will understand the importance for all pharmacy recommendations to be printed reviewed and signed by the physician in 24-72 hours of receipt. The UM will transcribe the order in PCC. • The learner will understand what medications cannot be crushed. The learner will understand to contact the MD to have the order revised. • The learner will understand the DO NOT CRUSH LIST will be available for reference on each medication cart. All education for current staff will be completed by 06/01/2024. As of 06/01/2024 any employee who has not received this training will not be allowed to work until the training has been completed. This includes all Licensed Nurses and Medication Aides, full time, part time, agency staff, and PRN staff. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

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F 756	Continued From page 8	F 756	The Director of Nurses will monitor compliance utilizing the F760 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include printing and review of pharmacy recommendations when received. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 06/01/2024	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer significant medications to 4 out of 16 residents (Resident #1, #18, #21, and #48) reviewed for medication administration. The facility also failed to follow medication administration guidelines for not crushing certain medications for 1 out of 16 residents reviewed for medication administration (Resident #42).	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	6/1/24

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F 760	Continued From page 9 Findings included: 1a) Resident #1 was admitted originally into the facility 01/31/22 and was readmitted on 3/23/23 with the diagnoses of cerebral infarction, chronic systolic congestive heart failure, hypothyroidism, hypertensive heart and chronic kidney disease with heart failure, epilepsy, and type 2 diabetes mellitus. A review of Resident #1's quarterly Minimum Data Set dated 8/31/23included that she is severely cognitively impaired, has diagnoses of heart failure, diabetes mellitus, stroke, dementia, seizure disorder, and schizophrenia. It further revealed that she had received insulin injections on 7 days and was taking high risk drug classifications of a diuretic and antidepressant. A review of Resident #1's comprehensive care plan initiated on 3/24/23 included the focus and interventions of a seizure disorder with a risk for injuries, the interventions included give seizure medication as ordered by doctor and to monitor/document the side effects and effectiveness. The focus and interventions of she used an antidepressant medication and had an increased risk for adverse side effects, the interventions included giving the antidepressant medication as ordered by the physician and to observe for/document side effects and effectiveness. The focus and interventions of the potential for dehydration or fluid volume deficit related to status post gastrostomy tube hydration and oral medications the interventions included to administer medications as ordered and monitor/document side effects and effectiveness. A focus and interventions of she had diabetes mellitus with risk for complications interventions	F 760	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 Based on record review and staff interviews the facility failed to administer significant medications to 4 out of 16 residents (Resident #1, #18, #21, and #48) reviewed for medication administration. The facility also failed to follow medication administration guidelines for not crushing certain medications for 1 out of 16 residents reviewed for medication administration (Resident #42). 1. Corrective action for resident(s) affected by the alleged deficient practice: On May 02,2024 the physician and RP were made aware of the medication that were missed. No new orders were provided by the physician for the missed medications for the below residents. Resident # 1, Resident #18, Resident # 21, Resident #48, Resident #42 The residents EMAR were reviewed and the physician was notified of the medication prescribed that could not be crushed and new prescription was provided 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 05/08/2024, the Director of Nurses initiated an audit of 100% of the Medication Administration for the last 14 days for all current residents. The audit consisted of a review of the Electronic	

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F 760	Continued From page 10 included to administer diabetes medication as ordered by the doctor and to monitor/document for side effects and effectiveness, and to monitor blood glucose levels as ordered by the physician. A review of Resident #1's November 2023 Medication Administration Record revealed no documentation of her medications scheduled for 9:00 AM on 11/29/23. These medications included: furosemide 40 mg daily for heart failure, phenobarbital 30 mg twice a day for seizures, and her blood sugar was not documented at 8:00 AM or 11:00 AM which determined if she received any human insulin per sliding scale. A review of Resident #1's facility record did not indicate adverse effects were noted by the medications not being administered. b) Resident #18 was admitted into the facility on 8/2/21 with the diagnoses of dementia, schizophrenia, sick sinus syndrome, hypertensive heart, and chronic kidney disease without heart failure. A review of Resident #18's quarterly Minimum Data Set dated 11/08/23 indicated that he was moderately cognitively impaired, and had diagnoses of hypertension, dementia, schizophrenia, renal insufficiency, and coronary artery disease. A review of Resident #18's comprehensive care plan dated 8/2/21 and revised 8/1/24 included the focus he received antipsychotic medication related to a diagnosis of paranoid schizophrenia with a risk of adverse side effects, the interventions included administer medication as ordered by the physician and discuss possible	F 760	Medical Administration Records (EMAR) notes to identify any medications that were not administered due to not being available for any reason. The audit identified 0 residents who had medications that were not administered. On 05/08/2024, the Director of Nurses notified the Medical Director of the medications that were not administered and the steps that were taken to prevent future occurrences of medications not being available and responsible parties were as well notified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 05/02/2024 the facility staff will continue to contact the Director of Nursing to communicate any obstacles that would prevent the staff from being able to administer medications as ordered. The Director of Nurses or designee will add review of the EMAR progress notes to their daily checklist to identify any residents who did not have medications available for administration. On 05/28/2024 the Director of Nurses initiated education on Medication Availability for all Licensed Nurses (RN's and LPN's), Medication Aides, Full Time, Part Time, PRN, and Agency Nurses on the following education: • The learner will understand the importance of ensuring that medications are always available to be given to the resident as ordered by the Physician.	

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F 760	Continued From page 11 side effects with the resident and his responsible party. A review of Resident #18's Medication Administration Record revealed no documentation of his scheduled medications scheduled for 9:00 AM on 11/29/23. These medications included haloperidol 5 mg daily for schizophrenia, amlodipine besylate 5 mg daily for hypertension, and carvedilol 3.125 mg daily for hypertension. A review of Resident #18 medical record did not indicate adverse effects were noted from the medications not being administered. c) Resident #21 was admitted into the facility on 12/1/15 and readmitted on 12/21/19 with diagnoses of cerebrovascular accident, hypertension, and seizures. A review of Resident #21 quarterly Minimum Data Set dated 10/20/23 included he was cognitively intact and had diagnoses of a stroke, hypertension, and seizures. A review of Resident #21's comprehensive care plan included a focus initiated on 2/22/16 that he was receiving an antiseizure medication with risk for toxic side effects and was at risk for injury due to seizure activity with interventions to administer medication as ordered by the physician. A focus initiated on 1/26/18 that he had hypertension with interventions to give antihypertensive medications as ordered and monitor for side effects including orthostatic hypotension and increased heart rate and effectiveness. A review of Resident #21's Medication Administration Record revealed no	F 760	• The learner will understand the steps necessary to obtain medications from the McNeill's Long-Term Care Pharmacy during business hours and after business hours for all situations. • The learner will understand the importance of administering ordered medications to prevent delay in treatment, uncontrolled pain or a change in condition. • Reordering needed medications for the med dispense if needed. • The learner will understand what medications cannot be crushed. The learner will understand to contact the MD to have the order revised. All education for current staff will be completed by 06/01/2024. As of 06/01/2024 any employee who has not received this training will not be allowed to work until the training has been completed. This includes all Licensed Nurses and Medication Aides, full time, part time, agency staff, and PRN staff. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the F760 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include review of the EMAR progress notes to identify any residents who have	

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F 760	Continued From page 12 documentation of his scheduled medications for 9 AM on 11/29/23. These medications included levetiracetam 1000mg twice a day for seizures, hydralazine hydrochloride 100 mg three times a day for hypertension, and labetalol hydrochloride 200 mg three times a day for hypertension. An interview conducted with Resident #21 on 5/2/24 at 1:00 PM indicated that he was not aware of ever missing any medications since his admission into the facility. A review of Resident #21's medical record did not indicate adverse effects were noted from the medications not being administered. d) Resident #48 was admitted into the facility on 2/10/21 with diagnoses of cerebral vascular accident, diabetes mellitus, hypertension, and hyperlipidemia. A review of Resident #48's quarterly Minimum Data Set dated 9/1/23 included that she was moderately cognitively impaired. A review of Resident #48's Comprehensive Care Plan dated initiated 5/12/21 included a focus of diabetes mellitus with a risk for complications with interventions of administer sliding scale insulin as ordered and give diabetes medications as ordered by the physician. A focus of at risk of complication of coronary artery disease related to hyperlipidemia with interventions of to give medications to control cholesterol level as ordered by the physician. A review of Resident #48's Medication Administration Record revealed no documentation of her scheduled medications for 9:00 AM on 11/29/23. These medications	F 760	medications that have not been administered due to not being available. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 06/01/2024	

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included insulin glargine inject 24 units subcutaneously one time a day for diabetes mellitus, metoprolol tartrate 25 mg daily for hypertension, amlodipine besylate 10 mg daily for hypertension, and a blood glucose check one time a day and to notify the physician if the blood glucose is less than 70 milligrams per deciliter or greater than 220 mg per deciliter.

A telephone interview was conducted on 5/6/24 at 10:07 AM with Nurse #12 who was scheduled on 11/29/23 to pass the 9:00 AM medications. She indicated she was not sure what time she had arrived at work on 11/29/23 however the facility was notorious for calling her in at the last minute. She further indicated that when she arrives late, she walks into several things requiring her immediate attention. She further stated that if the medications were not documented then the medications were not passed by her due to other issues, she was taking care of.

A review of Nurse #12's timecard indicated that she clocked in for work at 8:00 AM.

An interview was conducted on 5/6/24 at 10:33 AM with Medication Aide #12 who was originally scheduled to pass medications on 11/29/23 at 9:00 AM. She revealed that her job duties had been switched from a medication aide to nursing assistant duties due to call-ins on 11/29/23 and that she had not passed any medications prior to her job duties being changed.

An interview was conducted on 5/6/24 at 11:09 AM with the Director of Nursing revealed that she could not say if she was aware of the 9:00 AM medications not being administered on 11/29/23. She indicated that the normal procedure was for

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the nurse to notify the unit supervisor who then notified the Director of Nursing if there was an issue with the nurse passing medications to ensure the medications were given.

An interview with the Unit Supervisor could not be completed as he was out of the country.

An interview was conducted on 5/6/24 at 12:45 PM with the Physician who stated that there was a potential for harm if blood glucose were not obtained as ordered and if diabetic, antihypertensive, heart failure, antiseizure medications were not administered to Residents as prescribed. He was unaware of any increased monitoring or adverse effects related to the residents not being administered these types of medications the morning of 11/29/23. He stated that he was not aware of the medications not being administered on 11/29/23 which he expected to take place when these types of medications were not administered.

An interview was conducted on 5/6/24 at 1:30 PM with the Interim Administrator revealed that if there was an issue with administering medications that the nurse should have notified the unit supervisor so that arrangements to ensure the medications were administered could be accomplished.

2) Resident #42 was admitted into the facility on 3/11/24 with multiple diagnoses including atrial fibrillation (an irregular rapid heart rate that commonly causes poor blood flow), gastroesophageal reflux disease, and arthritis.

A review of Resident #42's admission Minimum Data Set dated 3/18/24 revealed she was

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moderately cognitively intact, had loss of food or fluids while drinking or eating, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and complained of difficulty or pain with swallowing, she had no weight loss and was on a mechanically altered diet.

A review of Resident #42's comprehensive care plan initiated on 3/18/24 included that she needed to be set up and supervised during meals and that she was on a mechanically altered diet.

A review of Resident #42's admission Physician orders for March 2024 included the following: Cardizem(used to treat high blood pressure) Controlled Delivery 120 milligrams (mg) daily , enteric coated aspirin (used to lower the risk of a heart attack, stroke and blood clots) 81 mg daily, Protonix (used to treat gastroesophageal reflux disease (GERD) and a damaged esophagus (the tube that allows food and liquid from the throat to pass to the stomach) delayed release 40 mg tablet daily, Tylenol 8 hour extended release one tablet every 8 hours as needed for pain, and pentoxifylline (used to treat poor blood circulation) extended release 400 mg tablet twice daily.

A review of Resident #42's Pharmacy Consultant review dated 3/21/24 included the following: the electronic medical record indicates medications are crushed. Please consider the following alternatives: 1) Change Cardizem CD 120 milligram (mg) capsule daily to diltiazem 30 mg (work with cardiology for change). 2) Change aspirin enteric coated 81 mg daily to aspirin chewable 81 mg daily. 3) Change protonix 40 mg delayed release to protonix 40 mg granule packet

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daily. 4) Change Tylenol 8 hour extended release 650 mg give one tablet every 8 hours as needed for pain to Tylenol 325 mg give 2 tablets as needed for pain. 5) Evaluate pentoxifylline extended release 40 mg tab twice a day for alternative as this extended release should not be crushed

An interview with the Pharmacy Consultant on 5/7/24 at 10:22 AM indicated that the aspirin was enteric coated to reduce the risk of stomach irritation, the protonix, pentoxifylline and Tylenol were designed to be released into the resident's system slowly and by crushing the medication the delayed release was compromised.

An interview was conducted on 5/7/24 at 10:31 AM with Nurse #13 indicated that she crushed Resident #42's medication prior to giving it to her. She further indicated that she does not remember if the medications are flagged on the electronic record not to be crushed and does not remember if there is a list of do not crush medications on the medication cart. She stated that she was aware of only the enteric coated medications were not to be crushed but not the other medications.

An interview was conducted on 5/7/23 at 3:11 PM with Nurse # 14 revealed that she crushed Resident #42's medication. She indicated that there is a list of do not crush medications on the medication cart but does not remember if the medications are flagged in the electronic record to not crush. She stated that she knew the enteric medications should not be crushed and she thought the pentoxifylline was not to be crushed.

An interview was attempted with the physician, but he was unavailable.

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F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		6/1/24

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F 887	Continued From page 18 (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain documentation of current Covid-19 vaccination status, eligibility screening, education, and offering of Covid-19 vaccination for facility staff. The failures regarding education, offering the vaccine, and maintaining records were found for 4 of 12 facility staff (Staff #1, Staff #2, Staff #3, and Staff #4) reviewed for infection control. The findings included: Facility Covid-19 Staff Vaccination Policy last revised 8/2023 indicated all newly hired employees will be offered the Covid-19 Vaccine. Current employees will be offered the vaccine when there is a change in the vaccine content or if they previously refused and now would like to obtain the vaccine. The facility Staff Vaccination Policy also indicated a master tracker would be	F 887	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 887 Based on staff interviews and record reviews, the facility failed to maintain this documentation for 4 of 12 staff members, it would be a violation of CMS regulations. This could potentially be a violation of F-Tag F887 under the CMS guidelines, which pertains to the facility's	

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F 887	Continued From page 19 created to list all current staff who routinely enter the facility and updated on an ongoing basis as new staff are onboarded. The tracker will include vaccination status and proof of vaccination will be maintained in a secured location. Review of facility records revealed Staff #1 was hired 2/9/2024, Staff #2 was hired 1/29/24, Staff #3 was hired 1/16/24 and Staff #4 was hired 4/25/24. The facility records revealed no documentation of the facility screening the four staff members for Covid-19 vaccine eligibility, offering the vaccine and educating the staff on the benefits, risks, and potential side effects of the vaccine. An interview was conducted with the facility Infection Preventionist (IP) on 5/3/24 at 9:12 AM. The IP explained she started working at the facility end of January 2024 and she could not find any records of employee Covid-19 vaccination documentation. The IP indicated she started looking for the staff Covid-19 vaccine tracking and documentation when the survey team asked for the information on 4/29/24 which she could not locate, and she started keeping the staff vaccination records straight on 5/2/24. She verbalized she was not made aware during hire that the staff vaccination records were not kept and that she needed to track it, screen, offer and provide education on Covid-19 vaccines to staff. During an interview on 5/3/24 at 9:30 AM with the Director of Nursing (DON), she stated she thought the previous Infection Preventionist (IP) was keeping track of staff Covid-19 vaccination status and offering education regarding Covid-19 vaccination. The DON stated going forward the current IP was going to keep track of employee	F 887	responsibility to educate and offer COVID-19 immunization as required or appropriate for residents and staff. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 05/01/2024 the SDC conducted interviews with Staff members #1, #2, #3, and #4 to ensure that their current Covid-19 vaccination status has been obtained. This was completed by ensuring their eligibility screening, education, and offering of Covid-19 vaccination are properly documented. This was competed on 05 /02/2024 1. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 05/01/2024, the DON/SDC reviewed all staff records to identify any other personnel who do not have proper documentation of their current Covid-19 vaccination status, eligibility screening, education, and offering of Covid-19 vaccination. Any identified staff were educated and offered the COVID vaccine, the signed declination or acceptance form was placed in the employee file and copy a was maintained by the SDC. They vaccine was given to the employees who accepted. A copy of the declination /acceptance consent form was placed in the employee file and a copy is maintain by the SDC. This was completed on 05/28/2024. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 887	Continued From page 20 vaccination status, screen, educate and offer Covid vaccines to facility staff. An interview was conducted on 5/3/24 at 10:11 AM with the facility Interim Administrator. She stated going forward all new hired employees would be screened for Covid-19 vaccination eligibility, offered the vaccine, and educated on the benefits, risks, and potential side effects of the vaccine. The Administrator further stated going forward, the IP or designee would ensure staff Covid vaccination status, screening and education was tracked and documented accurately.	F 887	On May 28, 2024 All staff were re-educated on the importance and requirement of maintaining accurate and complete documentation of their current Covid-19 vaccination status, eligibility screening, education of Covid-19 vaccination emphasized the importance of these requirements for infection control. This education was completed on May 28, 2024 All staff will be offered the COVID vaccine by May 28, 2024 and again offered if there are any updates or changes to the CDC COVID Vaccine Policy. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F887 Quality Assurance Tool for compliance with the educating and offering the staff the COVID vaccine. This audit will be completed weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor the compliance of offering the COVID Vaccine to employees. The results of the audits will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of	

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F 887	Continued From page 21	F 887	Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. DATE OF COMPLIANCE: June 1, 2024	