STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 07/12/2024

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ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

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F 000	INITIAL COMMENTS The survey team entered the facility on 7/9/2024 to conduct a complaint investigation. The survey team was onsite 7/9/2024 through 7/11/2024. Additional information was obtained offsite on 7/12/2024. Therefore, the exit date was 7/12/2024. Event ID # 3M0C11. The following intakes were investigated: NC00219268, NC00218127, and NC00218152. Two of the twelve complaint allegations resulted in a deficiency.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff and physicians the facility failed to ensure a staff member did not apply a dressing to a reopened pressure sore without obtaining orders and entering the information into the resident's record so future nurses would know to change the dressing and monitor the pressure	F 686	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	7/30/24

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

Electronically Signed | 07/29/2024

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F 686	Continued From page 1 sore. This was for one (Resident # 16) of four sampled residents reviewed for care of pressure sores. The findings included: Record review revealed Resident # 16 was admitted to the facility on 4/25/19. The resident in part had diagnoses which included diabetes, Alzheimer's disease, stroke resulting in hemiplegia and hemiparesis, neuropathy, and peripheral vascular disease. The resident was documented to be under hospice services on 1/11/24. Resident # 16's quarterly Minimum Data Set assessment, dated 7/9/24, coded the resident as cognitively impaired and as needing substantial to maximum assistance with his hygiene and bed mobility. The resident was also coded as having a pressure sore. Review of Resident # 16's care plan, dated 7/8/24, revealed the resident had skin impairment and was at risk for future skin impairment due to his diabetes, incontinence, impaired sensation related to neuropathy, and peripheral vascular disease. The care plan directed that the resident was to be on a low air mattress and staff were to follow facility protocols for treatments. According to wound physician notes Resident # 16 was identified to have a full thickness pressure sore to his right posterior thigh on 5/30/24. On 6/13/24 the Wound Physician documented this pressure sore was resolved following treatment. On 6/26/24 at 12:38 PM the facility treatment nurse documented Resident # 16's right posterior thigh wound was open again. Orders were	F 686	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. F686 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #16 received a total body skin assessment on 07/25/2024 by the RN Support nurse. The total body skin assessment revealed that resident #16 has a current wound with a treatment in place that is being managed by the treatment nurse or the staff nurse according to the physician□s order. On 07/13/2024, the Resource Nurse reviewed the orders to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 07/23/2024, resource nurses began identification of residents that were potentially impacted by this practice by completing total body skin assessments on all current residents. This audit was completed by reviewing 100% of current residents to identify any residents with wounds to ensure there was a treatment in place that was being managed by the treatment nurse or the staff nurse according to the physician□s order.	

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F 686	Continued From page 2 obtained on 6/26/24 to treat the pressure sore by cleaning the wound and applying calcium alginate with sliver followed by an island gauze dressing cover. The dressing was to be done three times per week. On 6/27/24 the Wound Physician documented he saw and evaluated the resident's posterior pressure sore to his thigh which had reopened. The wound measured 3 cm (centimeters) X 2 cm X 0.2 cm. The treatment nurse was interviewed on 7/10/24 at 10:14 AM and again on 7/12/24 at 12:34 PM and reported the following information. On 6/26/24 she had been notified by the Nurse Aide caring for Resident # 16 that the resident had a dressing which was in need of being changed to his posterior thigh. She had not been made aware before that day that the resident's right thigh pressure sore had opened again. When she (the treatment nurse) went into the room, there was a dressing on the resident's thigh and an odor coming from the wound. The dressing had drainage on it, and the dressing was in need of changing. When she removed the dressing, the wound did not look infected. It did have some granulation tissue with darker tissue in the wound bed. She looked in the record and found that no change in condition note had been entered into the resident's record noting the pressure sore had reopened. According to the treatment nurse this should have been done. There also were no treatment orders for the dressing she had found on the resident's pressure sore. She would not have known to change the dressing if the Nurse Aide had not informed her. She had been concerned that another facility nurse would apply a dressing to the pressure sore and not obtain	F 686	Additionally, the orders were reviewed to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds. This audit was completed on 07/26/2024. The results included: there were no residents identified with wounds that did not have treatment orders in place. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/25/2024, the Director of Nurses began in servicing all licensed nurse, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) full time, part time, and prn employees including agency on wound education and notification of new wounds. This education included all licensed nurses including agency staff. During this training, staff were educated on when to assess wounds, how to document wounds, the wound order process, and how to apply these concepts to safe guard all residents. This education was completed on 07/29/2024. Additionally, on 07/25/2024, the Nurse Consultant began educating the Interdisciplinary Team (IDT) to include the Director of Nurses (DON), Resource Nurses, and Minimum Data Set Nurse (MDS) on the policy to have routine clinical meetings to review high risk areas including new wounds to ensure there is a treatment in place that was being managed by the treatment nurse or the staff nurse according to the physician□s	

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F 686	Continued From page 3 orders or make documentation when it was found so that she or other staff (if she was off work) would know the resident was in need of dressing changes to the pressure sore. On 6/26/24, she called and got orders and made sure the Wound Physician saw the resident the next day. She reported the issue of finding a dressing on the resident's pressure sore with no documentation and orders to the facility resource nurse. The facility resource nurse had stated that she would tell the DON (Director of Nursing). She also later talked to the DON and found that the resource nurse had informed the DON also of what had been found. The facility's resource nurse was interviewed on 7/11/24 at 5:55 PM and reported the following information. She did talk to the treatment nurse on 6/26/24 and the treatment nurse indicated she had noticed the pressures sore on Resident # 16's posterior thigh had reopened. It was her (the resource nurse's) understanding that the treatment nurse had found the wound reopened on 6/26/24, and the treatment nurse did not mention about finding a dressing on the pressure sore without orders for the dressing. Medication Aide (MA) # 3 was interviewed on 7/11/24 at 9:13 AM and reported the following information which corroborated that the treatment nurse found a dressing on Resident # 16's thigh and had not been aware it was there. She (MA # 3) had been working as a Nurse Aide for Resident # 16 on 6/26/24. She had been caring for the resident when she noticed he had a dressing to his right thigh. There was a smell coming from the dressing and she could tell the wound had oozed. She went to get the treatment nurse to ask her to change the dressing. The treatment	F 686	order and that orders include preventative measures to prevent new skin issues and worsening of current wounds. This education was completed on 07/25/2024. The Director of Nurses has ensured that all RN□s and LPN□s full time, part time, and prn employees including agency staff in all departments who does not complete the in-service training will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for all RN□s and LPN□s in all departments. 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 DON or Designee will monitor compliance utilizing the F686 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week. 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: 07/30/2024	

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F 686	Continued From page 4	F 686		

nurse had been unaware of the pressure sore. No one had told the treatment nurse Resident # 16 had a pressure sore. Medication Aide # 3 stated she felt the treatment nurse really put her heart into caring for residents and it had appeared to really bother the treatment nurse that she had not been told about the pressure sore.

The DON, Administrator, and Nurse Consultant were interviewed on 7/12/24 at 3:59 PM and reported the treatment nurse had not made them aware of the pressure sore having a dressing on it without orders when it reopened. The Administrator pointed out that the treatment nurse had documented she had applied zinc oxide to the resident's buttocks/sacrum the previous day (6/25/24) and she (the Administrator) felt if the resident had a problem or dressing on the thigh area, the treatment nurse should have noticed it at that time (6/25/24). According to the DON, Administrator, and Nurse Consultant the facility has weekly wound meetings and nothing had been reported to them about an issue of applying dressings without orders. According to the administrative staff members, they questioned the credibility of things the treatment nurse would report because she had left employment that week (week of the survey).

Interview with the treatment nurse on 7/12/24 at 12:34 PM revealed she had left employment at the facility that week because she had been concerned regarding wound care practices that had been reported to administration and which she felt had gone unaddressed. She had specifically reported the problem with Resident # 16 having a pressure sore dressing without any orders or documentation.

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F 686	Continued From page 5 The Wound Physician was interviewed on 7/11/24 at 11:40 AM and reported the resident sweated a great deal and both moisture and heat can contribute to skin breakdown. Also, the resident's skin was more prone to break down on the right posterior thigh because he had previous skin break down in that area. The Wound Physician felt the reopening of the pressure sore was unavoidable. Resident # 16 was observed on 7/10/24 at 10:45 AM to have an open pressure sore to the posterior right thigh which had granulation tissue in the wound bed. The facility's Medical Director was interviewed on 7/12/24 at 9:25 AM and reported the following information. The Wound Physician does see residents weekly, but he does not always do a head -to toe assessment. Therefore, when an open area is found on a resident's skin, orders for treatment should be obtained prior to the Wound Physician seeing the resident when the skin breakdown is first observed by nursing staff.	F 686		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, staff, a Nurse Practitioner, Physician, and pharmacists for three (Residents # 5, # 10,	F 697	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	7/30/24

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F 697	Continued From page 6 and # 15) of three sampled residents reviewed for pain management the facility failed to provide pain medications for hospice and surgical residents per their orders and/or request and plan of care. For one of these three residents (Resident # 10), a nurse was aware the resident was in pain due to a recent hip replacement surgery but reported she could not access pain medication to administer to the resident resulting in the resident not receiving pain medication when she was in pain. Additionally, pharmacy records and medication administration records showed Resident # 10's personal supply of the pain medication had been received by the facility one hour and 34 minutes before it was administered during which timeframe Resident # 10 reported she was in pain. The findings included: 1. Resident # 10 was admitted to the facility on 7/8/24. Review of Resident # 10's hospital discharge summary, dated 7/8/24, revealed the resident had been hospitalized from 7/2/24 to 7/8/24 and underwent total hip replacement surgery. Per the hospital discharge summary Resident # 10 was to receive Oxycodone 5 to 10 mg (milligrams) every four hours as needed for pain for five days at the facility. The discharge summary also documented Resident # 10 was alert and oriented times four. Review of 7/8/24 facility admission orders revealed the following orders: Oxycodone 5 mg every four hours as needed for moderate to severe pain for five days; Give one tab for a pain level of 1-5, Give 2 tabs for pain level of 6-10. Acetaminophen table 325 mg three tablets every six hours as need for pain for 10 days.	F 697	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. F697-Pain Management 1. Corrective action for resident(s) affected by the alleged deficient practice: Corrective action was received for resident #10 on 07/09/2024 when Nurse #1 administered her Oxycodone at 12:11 AM. Nurse # 1 also documented administration of Acetaminophen on 7/9/24 at 12:13 AM. On 07/10/2024, the Resource Nurse completed a pain assessment and ensured resident was receiving pain medication upon request. No further corrective action was required. Corrective action was received for resident #15 on 07/01/2024 when Oxycodone was administered on 7/1/24 at 9:50 AM. Resident # 15□s Oxycodone was delivered to the facility on 06/30/2024. On 07/10/2024, the resource nurse completed a pain assessment and ensured resident was receiving pain medication upon request. No further corrective action was required. Corrective action was received for resident #5 on 07/02/2024 at 12:00 AM when Resident #5□s Oxycodone was administered as ordered. On 07/10/2024,	

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F 697	Continued From page 7 On 7/8/24 at 10:53 PM Nurse # 6 made a nursing entry noting Resident # 10 was alert and oriented and had voiced she "had been concerned" about the arrival of her medication and the resident was assured it would arrive in the pharmacy's night delivery to the facility. There were no other nursing notes about the resident's pain on 7/8/24. The nurse further charted the resident was pleased with care. Review of Resident # 10's July 2024 MAR (Medication Administration Record) revealed no Acetaminophen or Oxycodone were administered on 7/8/24. The first time Resident # 8 was documented to receive Oxycodone was on 7/9/24 at 12:11 AM. This was documented by Nurse # 1. Nurse # 1 also documented at the time of the Oxycodone administration that the resident's pain level was a "5" on a scale of 1 to 10. The first time Resident # 10 was documented to receive Acetaminophen was on 7/9/24 at 12:13 AM. Resident # 10 was interviewed on 7/9/24 at 10:20 AM and again on 7/11/24 at 2:50 PM and reported the following information. She was at the facility for short term rehabilitation following her hip replacement surgery. She had arrived around 4:30 PM on 7/8/24 and she had asked about her pain medication. A staff member had told her it would arrive around 10:00 PM that night. That evening she started hurting around 7:00 PM and made a staff member aware. She also rang her call bell at 10:30 PM and asked about it. Someone answered her call bell and told her the pain medication had still not arrived and gave her no further explanation. She waited for another	F 697	the Nurse Consultant Nurse completed a pain assessment and ensured resident was receiving pain medication as ordered. No further corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 7/22/2024, the Director of Nurses, Resource Nurse, Registered Nurse (RN) Supervisor, and Unit Support Nurses interviewed 100% of all current residents with a BIMS of 13 or above. The residents were interviewed and asked residents if their pain medication regimen provides effective pain management, if they are receiving their pain medication upon request, and if they have any concerns with their pain medications. The results included: All residents stated their pain medication provides effective pain management, all residents are receiving their pain medication upon request, and there were no residents with concerns about pain medication. Additionally, pain assessments were completed on current residents that were not interviewed. These residents were assessed to identify any pain that was not being addressed. The results included: No other resident affected by alleged deficient practice. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/22/2024, the Director of Nurses	

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F 697	Continued From page 8 hour and then she again rang her call bell at 11:30 PM. At that time a different nurse, whom she had not seen before, answered her call bell. She asked about her medication. The nurse said, "I don't know what you are talking about." She told this new nurse she was waiting for her pain medication. She (Resident # 10) finally received her pain medication around 12:15 AM on 7/9/24. Resident # 10 further reported the staff didn't offer her any acetaminophen while she was waiting on the Oxycodone, and it did not appear the nurses were communicating between themselves because the nurse who answered her call bell at 11:30 PM did not even realize she had been in pain and was waiting on her pain medication. Nurse # 7 was interviewed on 7/10/24 at 1:39 PM and reported the following information. She had cared for Resident # 10 from her admission time until 7:00 PM on 7/8/24.Resident # 10 was alert and oriented. She had talked to Resident # 10 around 5:00 to 5:30 PM and the resident reported she had taken her pain medication before leaving the hospital and she was okay at the time she (Nurse #7) talked to her. Prior to leaving at 7:00 PM Resident # 10 had not complained of pain. Nurse # 6 was interviewed on 7/10/24 at 3:09 PM and reported the following information. She had cared for Resident # 10 from 7:00 PM to 11:00 PM. The resident was hurting during her shift. She (Nurse # 6) did not have access to the facility's back up medications in order to obtain the Oxycodone, and she was also not aware of the procedures to obtain Oxycodone from the facility's back up supply. She knew the Oxycodone had been ordered and would be delivered in the night time pharmacy's delivery to	F 697	(DON) began educating all Licensed Nurses, RN□s, Licensed Practical Nurses (LPN□s), Medication Aides, full time, part time, including agency staff, and PRN (as needed) on the following topics: " Review Pain Management " How to obtain medications from the Automatic Dispense System " How to obtain medications from the back up pharmacy " The importance of ensuring that medications are always available to be given to the resident as ordered by the Physician. " Understand the steps necessary to obtain medications from the Pharmacy during business hours and after business hours for all situations. The DON will be responsible for ensuring Pain Management Education will be integrated into the standard orientation training and in the required in-service refresher courses for all Licensed Nurses, RN□s, Licensed Practical Nurses (LPN□s), Medication Aides, full time, part time, including agency staff, and PRN staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above identified staff who does not receive scheduled in-service training by 7/29/2024 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 697	Continued From page 9 the facility. She had told Resident # 10 the Oxycodone would arrive that night. She also told the night shift nurse the resident was waiting on the Oxycodone. The only medication the resident had available for pain during Nurse # 6's shift was Acetaminophen. Nurse # 6 reported Resident # 10 had said Acetaminophen did not do anything for her pain. Nurse # 1 had cared for Resident # 10 from 11:00 PM on 7/8/24 to 7:00 AM on 7/9/24. Nurse # 1 was interviewed on 7/11/24 at 12:39 PM and reported the following information. Resident # 10 was alert and oriented. She (Nurse # 1) did not recall being told anything in shift change report at 11:00 PM that Resident # 10 was in pain. After she came on duty, Resident # 10 rang her call light and told her she was hurting, and she gave her pain medication when the resident rang. The pharmacy manager was interviewed on 7/11/24 at 9:50 AM and reported the following information. The pharmacy received the faxed Oxycodone prescription at 5:04 PM on7/8/24 and they sent the Oxycodone that night. Their records showed that a facility nurse signed Resident # 10's personal supply of Oxycodone was received by the facility on 7/8/24 at 10:37 PM. If the facility needed to administer a dose of Oxycodone prior to the arrival of the resident's supply being delivered, they had a back- up supply and could keep up to 14 doses of Oxycodone 5 mg at a time on hand that the nurses should be able to access. The facility's medical director was interviewed on 7/12/24 at 9:25 AM and reported if a resident was complaining of pain, then it would be her expectation that the nurses would administer pain	F 697	and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F697 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The Director of Nursing will monitor compliance to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, Social Worker, Maintenance Director, Business Office Manager, and the Dietary Manager. Date of Compliance: 7/30/2024	

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medication.

2. Resident # 15 was admitted to the facility on 6/28/24 following a hospitalization from 6/7/24 to 6/28/24. Resident # 15's 6/28/24 hospital discharge summary included the following information. The resident had sustained a trimalleolar fracture of his left ankle (where three different areas of the ankle are fractured) with dislocation of the bone. Additionally, the resident had fractured his left third and fourth metatarsals bones in his foot. Upon his initial hospital admission on 6/7/24 the resident had presented with gross deformity of his ankle (a deformity which is easily visible to the naked eye). A CT (computerized tomography) of the resident's foot during hospitalization revealed a suspected ligament injury as well. The resident underwent two orthopedic surgeries for the injury while hospitalized. One was performed on 6/11/24 and another was performed on 6/18/24. The resident's history information also documented the resident had a history of substance abuse and depression. The discharge medications included orders for Oxycodone 5 mg (milligrams) one to two tablets every four hours as needed for pain up to five days. Additionally, the hospital discharge summary noted the resident was allergic to Oxycodone. The discharge summary also documented the resident should receive acetaminophen 1000 mg every eight hours on a scheduled basis.

Review of facility orders revealed upon admission on 6/28/24 Resident # 15 was ordered to receive Oxycodone 5 mg one tablet by mouth every four hours as need for moderate to severe pain for five days. The resident was to receive one 5 mg tablet for moderate pain of 1 to 5 on a scale of 1

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to 10 and two tablets (10 mg) for severe pain.

Additionally, on 6/28/24 Resident # 15 was ordered to receive acetaminophen 500 mg two tablets every eight hours as needed for pain for 30 days and Gabapentin 300 mg three times per day for a mood disorder. (Gabapentin is a seizure medication used at times to treat mood disorders and/or pain).

Review of Resident # 15's June 2024 MAR (Medication Administration Record) revealed the following information. From the dates of 6/28/24 through 6/30/24, Resident # 15 received no Oxycodone. During the dates, Resident # 15 was documented to receive Acetaminophen once. This was on 6/28/24 at 1:15 PM when Nurse # 8 documented she administered the Acetaminophen for a pain level of "7." Within a medication follow up note at 2:58 PM Nurse # 8 documented the Acetaminophen had been effective.

Further review of Resident # 15's MAR revealed a place on the MAR for nurses to document a pain assessment every shift. Within this area on the MAR, Nurse # 10 documented on 6/8/24 during the evening shift that the resident's pain was a "7." Following this assessment all other pain assessments for 6/28/24 through 6/30/24 reflected a "0."

Review of progress notes revealed on 6/28/24 at 5:07 PM a consultant pharmacist noted she had reviewed Resident # 15's medication regimen. The pharmacist noted she made recommendations but the recommendations were not documented in her note.

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On 6/29/24 at 11:36 AM Nurse # 9 documented she had contacted the pharmacy about the resident's Oxycodone and was advised that a hard prescription was needed. Nurse # 9 documented she faxed the prescription.

On 6/29/24 at 1:02 PM Nurse # 9 documented the resident denied pain or discomfort.

On 6/30/24 at 3:26 PM Nurse # 2 documented Resident # 15's Oxycodone was to arrive from the back up pharmacy that day and she had left the prescription for the oncoming nurse.

The first time Resident # 15 was documented on the MAR to receive Oxycodone was on 7/1/24 at 9:50 AM, at which time his pain level was documented to be a "5."

On 7/4/24 Resident # 15's admission Minimum Data Set assessment was completed revealing the following information. The resident was coded as cognitively intact and as experiencing pain frequently. The assessment coded the resident's worse pain as "severe" in the last five days.

Review of Resident # 15's care plan, initiated on 6/28/24, revealed that on 7/2/24 the staff added the information that the resident had acute pain related to his fracture. Staff were directed on the care plan to anticipate the resident's need for pain and administer pain medication as ordered.

Resident # 15 was interviewed on 7/10/24 at 8:55 AM and again on 7/11/24 at 10:45 AM. The resident reported the following information. He had arrived on 6/28/24 which corresponded to a Friday and had not received his Oxycodone for the first three days when he arrived although he

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had experienced pain, needed it, and asked for it. He would never have told someone his pain level was a "0" if asked. He had asked for the Oxycodone and been given different reasons why the staff could not give him the Oxycodone. One staff member had mentioned he had an allergy to Oxycodone. He had explained to them that he also had psoriasis and years ago a doctor had thought his psoriasis break out was due to Oxycodone when it was actually psoriasis. The allergy had mistakenly been placed on his chart. He had been getting the Oxycodone at the hospital following his surgery and explained all of that to the nursing staff as well. Then the staff also told him that there was none available in the facility back up to give him, and they had to get it from their pharmacy. It took them three days to get it from the pharmacy. The resident further reported he had been in the hospital for 21 days and pointed out that generally individuals were not kept in the hospital for 21 days unless there was something serious wrong. He explained that his fracture and surgery had been complicated and resulted in pain. On 6/30/24 he had not wanted to do all of his therapy session because the staff had not had his Oxycodone pain medication. It was 7/1/24 before he was given any Oxycodone for pain.

Nurse # 8 had cared for Resident # 15 when he was initially admitted on 6/28/24 (Friday). Nurse # 8 was interviewed on 7/11/24 at 2:00 PM and reported the following information. When Resident # 15 arrived there was information in his hospital record noting he had an allergy to Oxycodone. He also had an order and prescription for the Oxycodone. The resident was able to pull up his own health records through his personal health record portal on his phone and

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showed her that he had taken Oxycodone before. She thought he could not have had a serious reaction to the Oxycodone if he had been taking it at the hospital. She faxed the prescription to the pharmacy. She administered Acetaminophen to him, and he was fine with that. He did not complain of further pain after that on her shift. On the day of admission, she did not call and talk to the provider about the possible allergy. A couple days later she saw the Oxycodone had not come in and saw the allergy was still listed on the resident's chart. She talked to the provider at that point and the allergy was removed from the facility record.

Nurse # 10, who had documented Resident # 15 had a pain level of "7" on the evening shift of 6/28/24 (Friday) and a "0" for the night shift of 6/28/24, was interviewed on 7/11/24 at 1:00 PM and reported the following information. When she cared for Resident # 15 on 6/28/24 the resident had asked if his Oxycodone was at the facility. There was no Oxycodone in the back up supply at the facility for the nurses to access. She asked Resident # 15 about taking some Acetaminophen and he said he had already had it. He did not appear in pain. He just seemed concerned about where the Oxycodone was. He did not actually say he was hurting, and he did sleep though the night without problems. She had called the pharmacy and left a message that the facility needed the Oxycodone. She had passed that information on to the next nurse who followed her.

Nurse # 9, who had documented Resident # 15's pain level was a "0" on the dayshift of 6/29/24 (Saturday) for Resident # 15, was interviewed on 7/12/24 at 8:57 AM and reported the following

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information. The nurse who had cared for Resident # 15 on the previous shift reported that the Oxycodone prescription had already been faxed to the pharmacy. During the second medication pass on her shift Resident # 15 asked when the Oxycodone would come in. He did not mention that he was in pain during the day shift of 6/29/24 (Saturday). She called the pharmacy and they said that they had never received the Oxycodone prescription and so she refaxed it on that day. She did not call and clarify anything with a provider about the allergy listed. She assumed the allergy had been clarified when Resident # 15 was admitted. She saw the resident had been getting the Oxycodone at the hospital and knew the resident had shared information from his personal records he could access with a previous nurse about the Oxycodone.

Nurses # 1, who had documented Resident # 15's pain level of "0" for the evening and night shift of 6/29/24 (Saturday) and again on the night shift of 6/30/24 (Sunday), was interviewed on 7/11/24 at 12:39 PM and reported the following information. She did recall there being a problem obtaining Resident # 15's Oxycodone from the pharmacy. She thought the nursing staff had been waiting on the doctor to clarify about a possible allergy to the Oxycodone and getting it from the pharmacy. The resident had seemed okay with the delay in getting the Oxycodone and was okay with Acetaminophen if something was needed while they waited for it. She did not recall Resident # 15 having pain during the times she cared for him on 6/29/24 (Saturday) and 6/30/24 (Sunday) or the delay being an issue. She did not call the doctor to clarify anything.

Nurse # 2, who had documented Resident # 15's

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pain level was a "0" for the dayshift on 6/30/24 (Sunday), was interviewed on 7/11/24 at 10:18 AM and reported the following. She had first cared for Resident # 15 on 6/30/24. At the beginning of her shift she was told Resident # 15 did not have any Oxycodone. She checked on the reason the Oxycodone was not available and it appeared that the fax had not gone through to the pharmacy. She worked on communicating with the pharmacy and getting it from the pharmacy's back up pharmacy. The resident was able to communicate whether he did have pain. Since admission he had pain at times and other times did not. On 6/30/24 he did not say he had pain. The Oxycodone did not come in while she was working on 6/30/24.

Medication Aide (MA) # 4, who had documented Resident # 15's pain level was a "0" on the evening shift of 6/30/24 (Sunday), was interviewed on 7/10/24 at 5:20 PM, and reported she recalled nothing about what had occurred with Resident # 15 on the evening shift of 6/30/24. She was unsure if she had actually been assigned to care for him.

The facility's Occupational Therapist (OT) was interviewed on 7/12/24 at 12:12 PM and reported the following. She evaluated and treated Resident # 15 for the first time on 6/30/24 (Sunday). He sat up on the side of the bed and was able to turn independently in bed without any problems. He did not want to transfer to the wheelchair because he said he had not had his pain medication and he reported he had some pain in his foot. She had reported this to a nurse who said she would give him something. She saw the nurse take medications to him, but she did not know what all was given to him. She thought one of the

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medications was gabapentin. During treatment when the resident reported he did not want to transfer and was in pain, she had not observed any physical signs of pain such as grimacing. The OT reported pain can be subjective.

The pharmacy consultant, who reviewed the resident's medications on 6/28/24 (Friday), was interviewed on 7/12/24 at 12:02 PM and reported the following information. She helped with initial medication reviews when residents were admitted to ensure the discharge summary medications matched the facility's orders. She had reviewed Resident # 15's medications on 6/28/24 and had not noted or recommended anything regarding an allergy to Oxycodone. She was mainly looking to ensure medications had been transcribed correctly from the discharge summary to the facility's orders. She had made a recommendation to clarify with the provider about the resident's Acetaminophen. The discharge summary had noted it was to be scheduled and when the resident was admitted, it was ordered to be given as needed.

The pharmacy manager was interviewed on 7/11/24 at 9:50 AM and reported the following information. The facility should have back up medications located at the facility. They should be able to have 14 doses of Oxycodone 5 mg on hand in their back up supply, and they are responsible for reordering to keep their supply replenished. The pharmacy records showed that the pharmacy did not receive Resident # 15's prescription for Oxycodone until 6/30/24. The prescription had been written on 6/27/24 by the discharging hospital physician and the pharmacy did not know why the facility had not faxed it to them prior to 6/30/24. The pharmacy records

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showed that on 6/30/24 when they received the prescription, there was still some question about the resident having an allergy to the Oxycodone. That was clarified on 6/30/24. The pharmacy contracts with local pharmacies to supply the medication to the facility when it is needed outside of the pharmacy's routine delivery times. The pharmacy records showed once the allergy was clarified on 6/30/24 and they had received the prescription from the facility, the pharmacy in turn faxed the prescription to a local pharmacy near the facility to be filled on 6/30/24 at 3:06 PM.

The Resource Nurse was interviewed on 7/11/24 at 1:24 PM and reported Resident # 15 had an addiction to narcotic pain medications.

On 7/11/24 at 1:50 PM the DON (Director of Nursing) and Resource Nurse were accompanied as they checked the facility's back up supply of Oxycodone medications. At the time there were three tablets of Oxycodone in the supply. The DON And Resource Nurse reported that they reconciled/audited medications in the back up supply every month and the last time they reconciled medications in June 2024 there had been three Oxycodone 5 mg available in the back up supply.

The Administrator, DON (Director of Nursing), and the Nurse Consultant were interviewed on 7/11/24 at 2:00 PM regarding the resident's complaints that he had been in pain for three days without any Oxycodone being available and administered. The DON stated she would expect nurses to clarify an allergy for an ordered medication the same day when a resident arrived from the hospital. She had learned that Resident # 15's prescription had been faxed to the wrong

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number on 6/28/24 and the Oxycodone arrived on 6/30/24. The DON also stated she expected the nursing staff to have access to the facility's back up medications if the medication did not come from the pharmacy. The Administrator reported Resident # 15 had a history of narcotic abuse, and she questioned the credibility of his pain. The Administrator acknowledged there was still the issue with obtaining the Oxycodone and the Oxycodone should have been available to the nurses to access for administration to the resident when he requested it.

The Medical Director was interviewed on 7/12/24 at 9:25 AM and reported the following information. The resident had a history of substance abuse. He also had recent surgery and it was possible he could have pain associated with the surgery. Therefore, it was hard to tell how much pain the resident was truly having or if he was drug seeking. The staff should not discount that the resident was in pain just because he had a history of substance abuse. If there had been an issue with obtaining the Oxycodone because of a suspected allergy, then the staff should have clarified that on the day of admission with a provider. She saw Resident # 15 on 7/2/24 for the first time and the resident had reported he had pain over the past week-end 6/28/24 Friday to 6/30/24 (Sunday). On the day of her visit with the resident (7/2/24) he had already received his Oxycodone and appeared comfortable by visually looking at him. When asked he said he was still in pain on 7/2/24 although he had the Oxycodone.

3. Resident # 5 was admitted to the facility on 5/1/24. The resident had diagnoses in part which included colon cancer, history of breast mastectomy and breast cancer, scoliosis, chronic

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pain, history of compression fractures to the hip and shoulder, and history of opioid disorder. A review of Resident # 5's hospital discharge summary, dated 5/1/124 revealed the following information. The resident had been hospitalized from 3/28/24 until 5/1/24. It was during this hospitalization that the resident was found to have a new diagnosis of colon cancer and she was determined to be neither a surgical or chemotherapy candidate. A colonoscopy during the hospitalization determined that the resident had a 6 centimeter partially obstructing mass in her colon. The hospital discharge summary noted medications would be given for the resident to be comfortable and the resident was to receive Oxycodone and a Butrans (Buprenorphine) patch for comfort. (Both of these medications are used for pain.)

Resident # 5's significant change Minimum Data Set Assessment, dated 5/28/24, coded the resident as cognitively intact and as having no behavioral problems. The resident was coded as having pain occasionally which occasionally interfered with her daily activities.

Resident # 5's care plan, updated on 5/21/24, revealed the resident was placed on hospice services. This was added to the resident's care plan on 5/15/24. The goal was that Resident # 5 remain comfortable. The care plan also directed that staff should administer pain medications per order.

Reivew of Resident # 5's orders revealed Resident # 5's last order for the Buprenorphine patch was on 5/7/24 and was an active order. The order was for a patch which delivered 20 micrograms per hour of pain medication

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transdermally and was to be applied weekly. Resident # 5's last order for Oxycodone was dated 6/5/24 and was for 15 milligrams every three hours on a scheduled basis. This order was also an active order. Additionally, the resident had an order for Acetaminophen 650 mg every four hours as needed for pain and Morphine 20 mg/5 ml; give .25 (1 mg) every hour as needed for pain.

On 7/1/24 an order was given to hold Resident # 5's Oxycodone until it arrived from the pharmacy.

Review of Resident # 5's July MAR (Medication Administration Record) revealed the following. On 7/1/24 the 12:00 AM and 3:00 AM Oxycodone doses were administered. The Oxycodone 6:00 AM and 9:00 AM doses were not documented as administered. The 12:00 PM, 3:00 PM, 6:00 PM, and 9:00 PM Oxycodone doses were documented to be held.
Resident # 5's pain assessment for day, evening, and night shift on 7/1/24 indicated the resident had no pain. Nurse # 11 was the nurse who had documented the pain assessment for day shift.

Resident # 5 was documented to receive acetaminophen 650 mg at 6:30 PM by Nurse # 11 for a pain level of "5" on 7/1/24. At 12:00 AM on 7/2/24 Resident # 5's Oxycodone was resumed as ordered according to the MAR.

Resident # 5 was interviewed 7/9/24 at 9:42 AM and again on 7/11/24 at 2:45 PM. The resident reported the following information. She had chronic back pain, and she also had abdominal pain from her colon cancer. The cancer pain was different from the chronic back pain. The Bupernoprphine patch helped with the chronic

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pain and the Oxycodone helped with her cancer pain. The staff had run out of her Oxycodone, and she had missed it one day. She had been in pain and she had told them that. She did not understand how they could run out of her pain medication. During the interview, Resident # 5 was observed to have visible curvature of her body while lying in bed with the head of the bed slightly elevated. She appeared frail.

Nurse # 11 was interviewed on 7/10/24 at 11:37 AM and reported the following. The night shift nurse had told her in report on 7/1/24 that Resident # 5's Oxycodone was not there on 7/1/24 and so she called the physician and got an order to hold the medication. The Oxycodone was not in back up either. She informed the physician. The resident did not appear in pain. She gave Resident # 5 Acetaminophen and the resident was okay with that.

The pharmacy manager was interviewed on 7/11/24 at 9:50 AM and reported the following information. The pharmacy must have a prescription to fill Oxycodone and the facility must send the prescription and reorder it timely in order for a resident not to run out of a supply. They did not receive a prescription for the Oxycodone until 7/1/24 at 11:37 AM after the resident had already run out of her Oxycodone. Additionally, the facility was able to keep 14 doses of Oxycodone 5 mg tablets on hand in order to administer if needed. Additionally, the pharmacy contracts with local pharmacies in the facility's area to get medications to the facility if they are needed before the routine delivery of medications is made at night. The facility must contact the pharmacy to arrange a contracted pharmacy to send out a medication to them between routine deliveries,

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F 697	Continued From page 23 and the DON was responsible to reorder Oxycodone for the facility's back up supply to ensure it was replenished with what the staff needed. Interview with NP # 1 on 7/12/24 at 12:51 PM revealed he did not see Resident # 5 on the date of 7/1/24 but he was asked to write a prescription for her Oxycodone on that date. Therefore, he was not aware if the resident had been in pain. The facility's medical director was interviewed on 7/12/24 at 9:25 AM and reported the following information. If a resident is running low on a supply of pain medication, then the staff should let the provider know timely so that they can write the prescription ahead of time to avoid the resident running out of the pain medication. She had not been aware Resident # 5 had gone without the pain medication on 7/1/24 but she was aware the resident had multiple pain medications ordered and if her pain had been severe, the staff could have given the resident morphine.	F 697		
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		7/30/24

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F 755	Continued From page 24 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents, staff, and pharmacist for three of three residents (Residents # 5, # 10, #15) whose medications were reviewed the facility failed to ensure 1)nurses had access to back up pain medications in the facility's supply and the pain medications were replenished and available for administration (Residents # 10 and # 15) 2) narcotic pain prescriptions were faxed to the pharmacy correctly in order they be filled (Resident # 15) 3) allergies to pain medications were clarified in a time frame which did not interfere with the delivery of the pain medication from the pharmacy (Resident # 15) 4) prescription request for narcotic pain medication refills were submitted to the physician prior to a resident's supply running out (Resident # 5) and	F 755	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. F755 1. Corrective action for resident(s) affected by the alleged deficient practice: Corrective action was received for	

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F 755	Continued From page 25 5) the facility's accounting system of a controlled substance (Oxycodone) accurately reflected the exact number of tablets on hand in the facility's back up supply. For Resident # 10, the resident and staff reported the resident experienced pain when Oxycodone was not accessible to the nurse to administer to the resident. The findings included: 1a. Resident # 10 was admitted to the facility on 7/8/24. Review of Resident # 10's hospital discharge summary, dated 7/8/24, revealed the resident had been hospitalized from 7/2/24 to 7/8/24 and underwent total hip replacement surgery. Per the hospital discharge summary Resident # 10 was to receive Oxycodone 5 to 10 mg (milligrams) every four hours as needed for pain for five days at the facility. The discharge summary also documented Resident # 10 was alert and oriented times four. Review of 7/8/24 facility admission orders revealed the following orders. Oxycodone 5 mg every four hours as needed for moderate to severe pain for five days; Give one tab for a pain level of 1-5, Give 2 tabs for pain level of 6-10. Acetaminophen table 325 mg three tablets every six hours as need for pain for 10 days. On 7/8/24 at 10:53 PM Nurse # 6 made a nursing entry noting Resident # 10 was alert and oriented and had voiced she had been concerned about the arrival of her medication and the resident was assured it would arrive in the pharmacy's night delivery to the facility. There were no other nursing notes about the resident's pain on 7/8/24. Review of Resident # 10's July 2024 MAR (Medication Administration Record) revealed no	F 755	resident #10 on 07/09/2024 when the facility received a replenishment of residents Oxycodone on 07/08/2024 around 10:37 PM and resident #10 received Oxycodone around 12:15 AM on 7/9/24. No further corrective action was required. Corrective action was received for resident #15 when Resident # 15□s Oxycodone was delivered to the facility on 06/30/2024. Additionally, resident #15□s allergy was updated on 07/01/2024 to resolve his Oxycodone allergy. No further corrective action was required. Corrective action was received for resident #5 on 07/02/2024 at 12:00 AM when Resident #5□s Oxycodone was administered and the facility received a replenishment of the Oxycodone. Resident # 5's pain assessment for day, evening, and night shift on 7/1/24 indicated the resident had no pain. Nurse # 11 was the nurse who had documented the pain assessment for day shift. Resident # 5 was documented to receive acetaminophen 650 mg at 6:30 PM by Nurse # 11 on 7/1/24. No further corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 07/12/2024 and 07/16/2024 the Director of Nurses (DON) requested and received a replenishment of narcotics for the Narcotic Emergency Kit that was	

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F 755	Continued From page 26 Acetaminophen or Oxycodone were administered on 7/8/24. The first time Resident # 10 was documented to receive Oxycodone was on 7/9/24 at 12:11 AM. This was documented by Nurse # 1. Nurse # 1 also documented at the time of the Oxycodone administration that the resident's pain level was a "5" on a scale of 1 to 10. The first time Resident # 10 was documented to receive Acetaminophen was on 7/9/24 at 12:13 AM. Resident # 10 was interviewed on 7/9/24 at 10:20 AM and again on 7/11/24 at 2:50 PM and reported the following information. She was at the facility for short term rehabilitation following her hip replacement surgery. She had arrived around 4:30 PM on 7/8/24 and she had asked about her pain medication. A staff member had told her it would arrive around 10:00 PM that night. That evening she started hurting around 7:00 PM and made a staff member aware. She also rang her call bell at 10:30 PM and asked about it. Someone answered her call bell and told her the pain medication had still not arrived and gave her no further explanation. She waited for another hour and then she again rang her call bell at 11:30 PM. At that time a different nurse, whom she had not seen before, answered her call bell. She asked about her pain medication and received it around 12:15 AM on 7/9/24 for the first time. Nurse # 7 was interviewed on 7/10/24 at 1:39 PM and reported the following information. She had cared for Resident # 10 from her admission time until 7:00 PM on 7/8/24 and the resident had no complaints of pain during her time caring for her.	F 755	added to the Automatic Dispense System. On 07/23/2024, the DON completed an inventory of the Narcotic Emergency Kit allowing the nurses access to the available Narcotic Inventory. On 07/24/2024, the pharmacy validated the Narcotic Inventory completed by the DON. All licensed nurses now have access to the Narcotic Medications that are in the Emergency Kit. On 07/24/2024, the Pharmacy Consultant completed a review to identify and address new admission allergies for 100% of new admissions who were still residents at the facility. This audit was completed on 07/24/2024. The results included: There was one recommendation that was addressed by the DON on 07/24/2024. No further corrective action was completed. On 07/25/2024 the DON identified residents that were potentially impacted by this practice by completing an audit on 100% of current residents with active orders for narcotics to ensure they had an adequate supply of medications. This audit was completed on 07/26/2024. The results included: All residents had an adequate supply of narcotics on hand. On 07/26/2024, the DON implemented corrective action for those residents which included: Notifying the provider of those medications that required replenishment and working with the pharmacy to obtain medications that required replenishment.	

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F 755	Continued From page 27 Nurse # 6 was interviewed on 7/10/24 at 3:09 PM and reported the following information. She had cared for Resident # 10 from 7:00 PM to 11:00 PM. The resident was hurting during her shift. She (Nurse # 6) did not have access to the facility's back up medications in order to obtain the Oxycodone, and she was also not aware of the procedures to obtain Oxycodone from the facility's back up supply. She knew the Oxycodone had been ordered and would be delivered in the night time pharmacy's delivery to the facility. She had told Resident # 10 the Oxycodone would arrive that night. She also told the night shift nurse the resident was waiting on the Oxycodone. The only medication the resident had available for pain during Nurse # 6's shift was Acetaminophen. Nurse # 6 reported Resident # 10 had said Acetaminophen did not do anything for her pain. Nurse # 1 had cared for Resident # 10 from 11:00 PM on 7/8/24 to 7:00 AM on 7/9/24. Nurse # 1 was interviewed on 7/11/24 at 12:39 PM and reported she gave the Oxycodone on the night shift when she was made aware of the resident's pain. 1b. Resident # 15 was admitted to the facility on 6/28/24 following a hospitalization from 6/7/24 to 6/28/24. Resident # 15's 6/28/24 hospital discharge summary included the information that the resident had undergone surgery twice for a fractured ankle while hospitalized. The resident's discharge summary also included documentation the resident had a history of substance abuse and depression. The discharge medications included orders for Oxycodone 5 mg (milligrams) one to two tablets	F 755	On 07/29/2024, the Administrator validated that the pharmacy fax number was preprogrammed into the fax machine that the nurses have access to and accurately reflects the fax numbers sent from the pharmacy. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/24/2024, the Pharmacy Consultants were educated by the Pharmacy Director on the following: Completing initial reviews of residents to include the discharge summary vs the admission orders and that all allergy information has been correctly entered into the facility medical record as well as the pharmacy record. If there are any identified discrepancies, the Consultant Pharmacist will alert the facility as soon as possible so corrections can be made. Additionally, the Pharmacy Director will educate all Pharmacy Consultants on the need to review allergy information within the facility medical record compared to that entered into the pharmacy record during each regularly scheduled chart review. On 7/22/2024, the Director of Nurses (DON) began educating all Licensed Nurses, RN□s, Licensed Practical Nurses (LPN□s), Medication Aides, full time, part time, including agency staff, and PRN (as needed) on the following topics: " Review Pain Management	

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F 755	Continued From page 28 every four hours as needed for pain up to five days. Additionally, the hospital discharge summary noted the resident was allergic to Oxycodone. Review of facility orders revealed upon admission on 6/28/24 Resident # 15 was ordered to receive Oxycodone 5 mg one tablet by mouth every four hours as need for moderate to severe pain for five days. The resident was to receive one 5 mg tablet for moderate pain of 1 to 5 on a scale of 1 to 10 and two tablets (10 mg) for severe pain. Review of Resident # 15's June 2024 MAR (Medication Administration Record) revealed the following information. From the dates of 6/28/24 through 6/30/24, Resident # 15 received no Oxycodone. During the dates, Resident # 15 was documented to receive Acetaminophen once. This was on 6/28/24 at 1:15 PM when Nurse # 8 documented she administered the Acetaminophen for a pain level of "7." Within a medication follow up note at 2:58 PM Nurse # 8 documented the Acetaminophen had been effective. Further review of Resident # 15's MAR revealed a place on the MAR for nurses to document a pain assessment every shift. Within this area on the MAR, Nurse # 10 documented on 6/8/24 during the evening shift that the resident's pain was a "7." Following this assessment all other pain assessments for 6/28/24 through 6/30/24 reflected a "0." On 6/29/24 at 11:36 AM Nurse # 9 documented she had contacted the pharmacy about the resident's Oxycodone and was advised that a hard prescription was needed. Nurse # 9	F 755	" How to obtain medications from the Automatic Dispense System " How to obtain medications from the back up pharmacy " The importance of ensuring that medications are always available to be given to the resident as ordered by the Physician. " Understand the steps necessary to obtain medications from the Pharmacy during business hours and after business hours for all situations. The DON will be responsible for ensuring Pain Management and Pharmacy Services Education will be integrated into the standard orientation training and in the required in-service refresher courses for all Licensed Nurses, RN□s, Licensed Practical Nurses (LPN□s), Medication Aides, full time, part time, including agency staff, and PRN staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any RN, LPN, Medication Aides who does not receive scheduled in-service training by 7/29/2024 will not be allowed to work until training has been completed. The Pharmacy Director will be responsible for ensuring that Pharmacy Education will be integrated into the standard orientation training and in the required in-service refresher courses for all Pharmacy Consultants and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any Pharmacy Consultant who does not	

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F 755	Continued From page 29 documented she faxed the prescription. On 6/29/24 at 1:02 PM Nurse # 9 documented the resident denied pain or discomfort. On 6/30/24 at 3:26 PM Nurse # 2 documented Resident # 15's Oxycodone was to arrive from the back up pharmacy that day and she had left the prescription for the oncoming nurse. The first time Resident # 15 was documented on the MAR to receive Oxycodone was on 7/1/24 at 9:50 AM. On 7/4/24 Resident # 15's admission Minimum Data Set assessment was completed revealing the following information. The resident was coded as cognitively intact. Resident # 15 was interviewed on 7/10/24 at 8:55 AM and again on 7/11/24 at 10:45 AM. The resident reported the following information. He had arrived on 6/28/24 which corresponded to a Friday and the nurses had no Oxycodone to administer to him for the first three days. He had been given different reasons why the staff did not have any Oxycodone available. One staff member had mentioned he had an allergy to Oxycodone. He had explained to them that he also had psoriasis and years ago a doctor had thought his psoriasis break out was due to Oxycodone when it was actually psoriasis. The allergy had mistakenly been placed on his chart. He had been getting the Oxycodone at the hospital following his surgery and explained all of that to the nursing staff as well. Then the staff also told him that there was none available in the facility back up to give him, and they had to get it from their pharmacy. It took them three days to	F 755	receive scheduled in-service training by 7/29/2024 will not be allowed to work until training has been completed. 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 F755 Monitoring Tool weekly x 3 weeks then monthly x 2 months. The monitoring will review Pharmacy Services, procedures, pharmacist consultation and pharmacy records. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, Social Worker, Maintenance Director, Business Office Manager, and the Dietary Manager. Date of Compliance: 07/30/2024	

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get Oxycodone from the pharmacy.

Nurse # 8 had cared for Resident # 15 when he was initially admitted on 6/28/24 (Friday). Nurse # 8 was interviewed on 7/11/24 at 2:00 PM and reported the following information. When Resident # 15 arrived there was information in his hospital record noting he had an allergy to Oxycodone. He also had an order and prescription for the Oxycodone. The resident was able to pull up his own health records through his personal health record portal on his phone and showed her that he had taken Oxycodone before. She thought he could not have had a serious reaction to the Oxycodone if he had been taking it at the hospital. She faxed the prescription to the pharmacy. She administered Acetaminophen to him, and he was fine with that. He did not complain of further pain after that on her shift. On the day of admission, she did not call and talk to the provider about the possible allergy. A couple days later she saw the Oxycodone had not come in and saw the allergy was still listed on the resident's chart. She talked to the provider at that point and the allergy was removed from the facility record.

Nurse # 10, who had cared for Resident # 15 on the evening shift of 6/28/24 (Friday) and a the night shift of 6/28/24, was interviewed on 7/11/24 at 1:00 PM and reported the following information. When she cared for Resident # 15 on 6/28/24 the resident had not complained of pain. There was no Oxycodone in the back up supply at the facility for the nurses to access if he had complained of pain. She had called the pharmacy and left a message that the facility needed the Oxycodone. She had passed that information on to the next nurse who followed

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her.

Nurse # 9, who had documented Resident # 15's pain level was a "0" on the dayshift of 6/29/24 (Saturday) for Resident # 15, was interviewed on 7/12/24 at 8:57 AM and reported the following information. The nurse who had cared for Resident # 15 on the previous shift reported that the Oxycodone prescription had already been faxed to the pharmacy. She called the pharmacy and they said that they had never received the Oxycodone prescription and so she refaxed it on that day. She did not call and clarify anything with a provider about the allergy listed. The resident did not have pain on her shift.

Nurses # 1, who had documented Resident # 15's pain level of "0" for the evening and night shift of 6/29/24 (Saturday) and again on the night shift of 6/30/24 (Sunday), was interviewed on 7/11/24 at 12:39 PM and reported the following information. She recalled there being a problem obtaining Resident # 15's Oxycodone from the pharmacy. She thought the nursing staff had been waiting on the doctor to clarify about a possible allergy to the Oxycodone and getting it from the pharmacy. The resident had seemed okay with the delay in getting the Oxycodone and was okay with Acetaminophen if something was needed while they waited for it. The resident had not complained of pain.

Nurse # 2, who had documented Resident # 15's pain level was a "0" for the dayshift on 6/30/24 (Sunday), was interviewed on 7/11/24 at 10:18 AM and reported the following. She had first cared for Resident # 15 on 6/30/24. At the beginning of her shift she was told Resident # 15 did not have any Oxycodone. She checked on

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the reason the Oxycodone was not available and it appeared that the fax had not gone through to the pharmacy. She worked on communicating with the pharmacy in order to get them to send the Oxycodone.

1c. Resident # 5 was admitted to the facility on 5/1/24. The resident had diagnoses in part which included colon cancer, history of breast mastectomy and breast cancer, scoliosis, chronic pain, history of compression fractures to the hip and shoulder, and history of opioid disorder.

Resident # 5's significant change Minimum Data Set Assessment, dated 5/28/24, coded the resident as cognitively intact.

Reivew of Resident # 5's orders revealed Resident # 5's last order for the Buprenorphine patch was on 5/7/24 and was an active order. The order was for a patch which delivered 20 micrograms per hour of pain medication transdermally and was to be applied weekly. Resident # 5's last order for Oxycodone was dated 6/5/24 and was for 15 milligrams every three hours on a scheduled basis. This order was also an active order.

On 7/1/24 an order was given to hold Resident # 5's Oxycodone until it arrived from the pharmacy.

Review of Resident # 5's July MAR (Medication Administration Record) revealed the following. On 7/1/24 the 12:00 AM and 3:00 AM Oxycodone doses were administered. The Oxycodone 6:00 AM and 9:00 AM doses were not documented as administered. The 12:00 PM, 3:00 PM, 6:00 PM, and 9:00 PM Oxycodone doses were documented to be held.

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Resident # 5's pain assessment for day, evening, and night shift on 7/1/24 indicated the resident had no pain. Nurse # 11 was the nurse who had documented the pain assessment for day shift.

Resident # 5 was documented to receive acetaminophen 650 mg at 6:30 PM by Nurse # 11 on 7/1/24. At 12:00 AM on 7/2/24 Resident # 5's Oxycodone was resumed as ordered according to the MAR.

Resident # 5 was interviewed 7/9/24 at 9:42 AM and again on 7/11/24 at 2:45 PM. The resident reported the facility had run out of her Oxycodone on 7/1/24.

Nurse # 11 was interviewed on 7/10/24 at 11:37 AM and reported the following. The night shift nurse had told her in report on 7/1/24 that Resident # 5's Oxycodone was not there on 7/1/24 and so she called the physician and got an order to hold the medication. The Oxycodone was not in back up either. She informed the physician. The resident did not appear in pain. She gave Resident # 5 Acetaminophen and the resident was okay with that.

The facility resources nurse was interviewed on 7/11/24 at 1:24 PM and reported the following information. Currently the facility was staffed with approximately 95% agency nurses and the facility had new nurses each day. Nurses must be given access to the back- up supply in order for them to obtain medications from it. A lot of times the nurses didn't have access to the facility's back up supply, and it took two nurses to sign out narcotics such as Oxycodone from the back- up supply. While she was at the facility, she would

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get medications from the back -up supply all the time for the nurses.

The pharmacy manager was interviewed on 7/11/24 at 9:50 AM regarding why the Oxycodone was not available for Residents # 5, #10, and # 15 and the pharmacy manager reported the following information. The pharmacy makes routine deliveries to the facility daily. If the facility needed to administer a dose of Oxycodone prior to the arrival of any resident's supply being delivered, the facility had a back- up supply at the facility and could keep up to 14 doses of Oxycodone 5 mg at a time on hand that the nurses should be able to access. The pharmacy records as of 7/11/24 were showing that the facility had no doses of Oxycodone 5 mg in their back up supply even if they had tried to access it. It was the responsibility of the DON (Director of Nursing) to reorder the controlled substances for the back- up supply kept at the facility. The last time the facility's back up supply was replenished was on 3/12/24. The pharmacy records showed the facility had tried to reorder Oxycodone on 6/19/24 but the reorder was unsuccessful. This was because the pharmacy only received a faxed order form from the facility. In order for the pharmacy to send the ordered back up supply of Oxycodone a specific form, which is signed by the DON, must be completed and the actual hard copy of the form submitted to the pharmacy. The pharmacy received only a faxed copy of the required form. The pharmacy called the facility and let them know that they still needed the hard copy of the form but the pharmacy had not entered the date in their records when they had called the facility to request the hard copy of the required form. Therefore, the pharmacy did not send any replenishing doses to the facility since

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3/12/24. Additionally, the pharmacy contracts with pharmacies which are local to the facility to fill prescriptions if a medication is needed before the daily delivery can arrive and a medication is not in their back up supply. The nurses must call the main pharmacy and request this. Then the main pharmacy will arrange for the local pharmacy to deliver the medication. Specifically for Resident # 10, who had hip surgery and the nurse reported she could not access any back up supply of the Oxycodone to give her, the pharmacy records showed that Resident # 10's Oxycodone prescription had been received at 5:04 PM on7/8/24. The pharmacy sent the Oxycodone that night in their routine delivery. Pharmacy records showed that a facility nurse signed Resident # 10's Oxycodone was received by the facility on 7/8/24 at 10:37 PM. (which was one hour and thirty -four minutes before Resident # 10 was documented to receive it on the MAR.)
Regarding Resident # 15, the pharmacy records showed that the pharmacy did not receive Resident # 15's prescription for Oxycodone until 6/30/24 although he was admitted on 6/28/24. The prescription had been written on 6/27/24 by the discharging hospital physician and the pharmacy did not know why the facility had not faxed it to them prior to 6/30/24. The pharmacy records showed that on 6/30/24 when they received the prescription, there was still some question about the resident having an allergy to Oxycodone which had not been clarified. That was clarified on 6/30/24. The pharmacy records showed once the allergy was clarified on 6/30/24 and they had received the prescription from the facility, the pharmacy in turn faxed the prescription to a local pharmacy near the facility to be filled on 6/30/24 at 3:06 PM. Regarding Resident # 5, the pharmacy pharmacy must have

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a prescription to fill Oxycodone and the facility must send the prescription and reorder it timely in order for a resident not to run out of a supply. The pharmacy did not receive a prescription for Resident # 5's Oxycodone until 7/1/24 at 11:37 AM after the resident had already run out of her Oxycodone.

The Administrator, DON (Director of Nursing), and the Nurse Consultant were interviewed on 7/11/24 at 2:00 PM regarding residents' complaints about no Oxycodone being available per their needs and orders. Regarding Resident # 15, the DON stated she would expect nurses to clarify an allergy for an ordered medication the same day when a resident arrived from the hospital. She had learned that Resident # 15's prescription had been faxed to the wrong number on his admission date and the Oxycodone arrived on 6/30/24. The DON also stated she expected the nursing staff to have access to the facility's back up medications if the medication did not come from the pharmacy. The Administrator acknowledged the Oxycodone should have been available to the nurses to access for administration to residents when needed.

On 7/11/24 at 1:50 PM the DON (Director of Nursing) and Resource Nurse were accompanied as they checked the facility's back up supply of Oxycodone medications. The back up supply was locked and required computer access to open the supply. When opened on 7/11/24 at 1:50 PM there were three tablets of Oxycodone 5 mg in the supply although the pharmacy manager had reported the supply had not been replenished since 3/12/24 and the main pharmacy records showed the count should be zero. The DON And Resource Nurse reported that they

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reconciled/audited medications in the back up supply and the last time they reconciled medications in June 2024 there had been three Oxycodone 5 mg tablets available in the back up supply. When interviewed about why the pharmacy's accounting system of the facility's back up supply was showing zero doses of Oxycodone and it had been reported by Nurse # 10 that there was no Oxycodone in the back up supply on 6/28/24 when Resident # 15 arrived and prior to Resident # 5 and Resident # 10 needing Oxycodone, the DON and Resource did not know why accounting records would be showing zero. The DON reported around February 2024 there had been some computer glitches with the system, but they had been rectified and speculated that the computer accounting system might not be reflecting the correct count to the nurses or to the pharmacy. The DON also reported the pharmacy had not told her she needed to send a hard copy of the narcotic reorder form, or she would have certainly done so.