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E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		8/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/09/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure alternative skilled nursing facilities that would be used in an emergency evacuation of the facility were updated in the Emergency Preparedness (EP) plan. This practice had the potential to affect all staff and residents. Findings included: The facility's EP plan was signed by the Administrator as last reviewed on 4/2/2024. A review of the EP plan on 7/12/2024 listed three skilled nursing facilities as alternative sites for evacuation during an emergency disaster. In an interview with the Administrator on 7/12/2024 at 12:30 pm, she stated the Maintenance Director was responsible for updating the EP plan, and stated the listed alternative facilities in the EP plan for emergency evacuation were incorrect. The Administrator stated the facility used sister facilities within the company as alternative facilities for emergency evacuation. In an interview with the Maintenance Director on 7/12/2024 at 2:00 pm, she stated she was responsible for updating the EP plan and when	E 004	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. E004 DEVELOP AN EP PLAN AND UPDATE ANNUALLY 1. Plan for correcting specific deficiency. The process that led to deficiency cited. On 7/12/24 the Emergency Preparedness Plan was reviewed and the outdated transfer contracts were removed and the current contracts for sister facilities #12, #13, #14 were added to the plan. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The Emergency Preparedness Plan was taken to the Quality Assurance Performance Improvement meeting on 8/9/24 and reviewed by the Committee. The Committee consists of the Administrator, Director of Nursing,	

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E 004	Continued From page 2 she updated the EP plan in April 2024, she stated she was unable to locate the information that listed which sister facilities served as the facility's alternative sites for emergency evacuation. She stated the EP plan should have been updated to reflect the sister facilities as emergency alternative facilities for evacuation in the EP plan On 7/12/2024 at 2:44 pm, the Administrator provided three contracts dated 1/1/2024 for the following three sister facilities for emergency evacuation of the facility: Sister Facility #12, Sister Facility #13 and Sister Facility #14. In an interview with the Administrator on 7/12/2024 at 2:44 pm, she stated the Maintenance Director updated the EP plan in April 2024. She explained the corporate office had placed the information regarding use of sister facilities as alternative facilities for emergency evacuations in a new book, and she was not aware the information was in the book. She stated the sister facilities (Sister Facility #12, Sister Facility #13 and Sister Facility #14) should have been listed in the EP plan as the alternative facilities for emergency evacuation.	E 004	Maintenance Director, Medical Director, Social Workers, Rehabilitation Manager, Dietary Manager, Medical Records Manager, Business Office Manager and the Admission Team. The Committee reviewed the plan to ensure all of the contents of the plan were up-to-date and the information was accurate. 3. Systemic Measures: The Emergency Preparedness plan will be reviewed by the Quality Assurance Performance Improvement Committee annually. The Committee, not only the Maintenance Director and Administrator, will participate in the review and assist with updating the manual. 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 results of the review by the Quality Assurance Performance Improvement (QAPI) Committee will be brought to the Quality Assurance meetings by the Maintenance Director for review. The Emergency Preparedness plan will be reviewed through a QAPI meeting by the Committee monthly for three months, quarterly for three quarters and then annually. Negative findings will be corrected by the Committee if noted. Addition interventions will be added and monitored by the Committee to ensure continued compliance.	
F 000	INITIAL COMMENTS A recertification and complaint investigation	F 000		

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F 000	Continued From page 3 survey was conducted from 07/08/24 through 07/12/24. Event ID# 829O11. The following intakes were investigated: NC00216518, NC00217163, NC00218448, and NC00219148. 2 of the 14 complaint allegations resulted in deficiency.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		8/12/24

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F 645	Continued From page 4 services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record review,	F 645	The statements made on this plan of	

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F 645	Continued From page 5 the facility failed to ensure 1 of 1 resident (Residents #58) who had diagnoses of schizophrenia and anxiety had a Preadmission Screening and Resident Review (PASRR) prior to admission. The findings were: The North Carolina Medicaid Uniform Screening Tool (NC MUST) record for Resident #58 revealed the resident had a Level II PASRR for serious mental illness in place from 4/02/15 through 3/29/22. On 3/30/22 Resident #58 was changed to a Level I PASRR. There was no evidence a PASRR screening was conducted since 3/30/22. Resident #58 was admitted to the facility on 4/18/24 with diagnoses including schizophrenia and anxiety disorder. Review of Resident #58's quarterly Minimum Data Set (MDS) dated 5/8/24 revealed he had severe cognitive impairment, no behaviors, had diagnoses of schizophrenia and anxiety disorder, and had not received psychotropic medication in the past 7 days. Review of Resident #58's progress notes revealed a note by the Social Worker dated 6/18/24 indicating Resident #58 was going to be moved to a long-term care hall for continued facility care. In an interview on 7/09/24 at 3:17 PM, the Administrator revealed Resident #58's PASRR dated 3/30/22 was the Level I PASRR received from the hospital prior to the resident's 4/18/24 admission. She explained, when a resident was	F 645	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. F645 The facility failed to refer a resident for a level II Preadmission Screening and Resident Review(PASRR) upon a significant change in status assessment. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 07/ 09 /2024, the Social Worker submitted through NCMUST. a Preadmission Screening and Resident Review (PASRR) for resident # 58 . It was submitted and accepted on 7/09/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 8/8/2024, the Social Workers completed 100 % audit of all residents who have had a new diagnosis assigned to them from April l, 2024 to date, in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who received a new diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation	

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F 645	Continued From page 6 admitted for short-term rehabilitation, the facility did not submit a new Level I PASRR to the state until they knew if a resident was going to transition to long-term care. The Administrator further explained, a new Level I PASRR was not submitted because the facility did not know if he was going to stay long term. Once that decision was made, a new PASRR request would be submitted. The Administrator said the Social Worker was going to submit a PASRR request on 7/09/24 because a decision had recently been made that he would be staying for long-term care. The Administrator was not aware residents diagnosed with a serious mental illnees required a PASRR evaluation prior to admission. In an interview on 7/10/24 at 9:05 AM, the Marketing Director said the facility accepted the PASRR that was submitted by the hospital when a resident was admitted. The policy in the facility was to accept a PASRR that was open and active, regardless of how old it was. The facility would not submit a new Level I PASRR at admission and would use the information in the state PASRR system.	F 645	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 8/5/2024, the Nurse Consultant completed education with the facility Social Worker/Admission Coordinator and Health Information Manager which included the PASRR assessment process and requirements for when a level II PASARR is to be completed. The Health Information Manager will notify the Social Worker when a new diagnosis has been added that would potentially qualify for a level II PASARR. On, 8/06/2024 the Administrator made the Health Information Manager aware of the responsibility of notifying the Social Worker of when a new diagnosis has been added that would potentially qualify a resident for a level II PASRR. The Administrator also, on 08/06/2024 educated the Social Workers of the responsibility of requesting Level II PASRR reviews when indicated. Any Social Worker, Health Information Manager or Admissions Coordinator who did not receive in-service training by 08/12/2024 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all newly hired Social Workers, Admission Personnel and Health Information Managers and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 645	Continued From page 7	F 645	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 Social Worker or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON 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 Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		8/12/24

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F 690	Continued From page 8 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and a physician interview, the facility failed to ensure a collected urine specimen was delivered to the laboratory for an analysis for 1 of 1 resident reviewed for urinary tract infections and urinary catheters. This resulted in another urine specimen having to be collected for analysis and delayed the start of treatment for a urinary tract infection (Resident #73). The findings included:	F 690	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 date or dates indicated.	

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Resident #73 was admitted to the facility on 5/14/2024 with diagnoses including pneumonia.

Nursing documentation dated 5/18/2024 at 6:40 pm by Nurse #1 reported Resident #73 complained of burning on urination and a urine specimen was collected. Nurse #1 further recorded the physician, and Resident #73's Representative was aware of Resident #73's complaint of burning with urination and a urine specimen was collected for analysis.

A review of the laboratory patient log sheet dated 5/18/2024 recorded a urine for Resident #73 in a refrigerator near the rehabilitation nursing station for a urinalysis and culture and sensitivity test. There was no date or signature on the laboratory patient log sheet dated 5/18/2024 that laboratory personnel had picked up the urine specimen on 5/18/2024.

There were no urinalysis results for the urine specimen collected on 5/18/2024 for Resident #73.

The admission Minimum Data Set (MDS) assessment dated 5/21/2024 indicated Resident #73 was moderately cognitively impaired, frequently was incontinent of urine and required assistance with toileting.

Nursing documentation dated 5/21/2024 at 2:33 am by Nurse #3 reported a urine specimen was collected for a urinalysis and culture and sensitivity test and picked up by the laboratory staff on 5/21/2024 at 2:30 am.

A review of the laboratory patient log sheet dated 5/21/2024 recorded a urine for Resident #73 in a

F 690

F690
The facility failed to ensure that a collected urine specimen was delivered to the lab for analysis for 1 of 1 resident.
Corrective Action for Affected Residents
For resident #73 the ordered urine specimen was recollected on 05/21/2024 and picked up by the laboratory on 05/ 21/2024. The results were received on 05/ 22/ 2024 and the physician was notified of the results on 05/ 22/2024. Antibiotic therapy was ordered by the physician based on the results of the urine culture and sensitivity received from the lab on 05/23/2024.
Corrective Action for Potentially Affected Residents
All residents who reside in the facility have the potential to be affected by this alleged deficient practice. On 08/ 6 /2024 the Director of Nurses identified residents that were potentially impacted by this practice by completing a lab order audit on all current residents for the last 14 days to assure that the ordered lab had been sent to the lab timely, results obtained and the physician notified of the results timely.
The results included: No concerns were identified.
This was completed on 08/7 /2024.
Systemic Changes
On 8/06/2024 the Director of Nursing/Assistant Director of Nurses began in-servicing all current full time, part time and as needed licensed nurses.
This in-service included the following topics:
• Follow through on any lab order when entered/confirmed or signing off on

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refrigerator near the rehabilitation nursing station for a urinalysis and culture and sensitivity test. The laboratory patient log sheet dated 5/21/2024 showed laboratory personnel had signed picking up the urine specimen collected on 5/21/2024.

The urine specimen dated 5/21/2024 recorded the results of the urinalysis was reported at 5/21/2024 at 9:19 pm. The urinalysis report did not specify who received the urinalysis report or how resident #73's urinalysis was reported to the facility.

A review of the urinalysis dated 5/21/2024 for the urine specimen collected on 5/21/2024 reported the following elements present in the urine: white blood cells, bacteria, squamous epithelial cells and moderate amount of mucous.

A physician progress note dated 5/22/2024 recorded Resident #73's Representative stated Resident #73 complained of dysuria (painful or difficulty urinating) a few days ago but not on 5/22/2024, and Resident #73's urine looked like it could be infected.

The culture and sensitivity test on the urine specimen dated 5/21/2024 indicated the urine specimen was obtained by conducting straight catheterization (insertion of a tube into the urinary bladder to collect urine).The culture and sensitivity test reported on 5/23/2024 at 9:14 am the microorganism, extended spectrum beta-lactamase (ESBL), was present in Resident #73's urine and had the greatest sensitivity to Sulfamethoxazole-Trimethoprim (an combination of two antibiotics used to treat urinary tract infections).

F 690

resident's electronic medical record for their shift.

- Confirming the lab slip is present in lab book and that the specimen is placed appropriately in the lab refrigerator for pick up by the lab.
- Assuring that all specimens have been picked up timely by the lab by reviewing the laboratory patient log sheet each shift.
- Notifying the lab timely if a specimen was not picked up by the lab and notification of the physician with documentation.
- Notification of the physician timely of the lab results and documentation of the notification and any orders received.

The Director of Nursing will ensure that any staff clinical who has not received this training by 08/11/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

Quality Assurance

The Director of Nurses or designee will monitor this issue using the Lab Process Quality Assurance Tool for compliance with obtaining lab specimens, assuring the lab specimen was picked up by the lab timely and that the physician is notified of the results timely. This will be completed weekly for 2 weeks then monthly x 3 months or until resolved. Reports will be presented to the weekly Quality

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F 690	Continued From page 11 On 5/23/2024, a physician order was written for Resident #73 to receive Sulfamethoxazole-Trimethoprim 800-160 milligrams (mg) tablet two times a day for a urinary tract infection for ten days. A review of the May and June 2024 Medication Administration Record (MAR) for Resident #73 recorded Sulfamethoxazole-Trimethoprim 800-160 mg tablet was administered from 5/23/2024 at 5:00 pm to 6/2/2024 at 9:00 am twice a day for ten days. Resident #73's care plan last reviewed on 6/22/2024 did not include a focus for urinary tract infection. On 7/11/2024 at 4:02 pm in an interview with Nurse #1, she stated on 5/18/2024 a urine specimen was collected from Resident #73 and was placed in the refrigerator for the laboratory personnel to pick up during the night hours. She stated due to the laboratory personnel was not reporting to the facility on weekends and the nursing staff not aware the laboratory personnel would not be picking up Resident #73's urine specimen from 5/18/2024, another urine specimen had to be recollected. She explained a urine specimen had to be discarded if in the refrigerator for more than forty-eight hours. Nurse #1 stated due to the laboratory personnel not picking up the urine specimen collected on 5/18/2024, there was a delay in obtaining results from a urine specimen to start antibiotics for resident #73's urinary tract infection. On 7/11/2024 at 4:52 pm in an interview with the Administrator, she stated she had a contract with a laboratory company that came to the facility	F 690	Assurance Committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

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nightly to pick up urine specimens for analyzing and was unable to recall a time receiving notification that the laboratory company would not be reporting to the facility to collect urine or blood specimens.

On 7/12/2024 at 2:06 pm in an interview with the Director of Nursing, she stated a urine specimen was collected on 5/18/2024 for Resident #73 and was not aware why the laboratory personnel did not pick up the urine specimen. She explained Resident #73's urine specimen was listed on a laboratory patient log dated 5/18/2024. She further stated Nurse #1 and nursing staff need to follow up and check to ensure urine specimens have been picked up by the laboratory personnel. She stated treatment for Resident #73's urinary tract infection was delayed due to laboratory personnel not picking up the 5/18/2024 urine specimen and staff having to recollect a urine specimen for analysis for Resident #73.

On 7/12/2024 at 8:39 am in an interview with the Administrator, she stated based on the review of other laboratory patient logs dated 5/18/2024, laboratory personnel were in the facility to pick up urine or blood specimens that had been collected on other residents. She explained laboratory personnel should have picked up the collected urine specimen of Resident #73 on 5/18/2024 and Nurse #1 should had checked the refrigerator the next day to ensure the urine specimen was picked up by the laboratory personnel. She said, due to having to recollect Resident #73' s urine specimen, there was a delay in diagnosing Resident #73 with a urinary tract infection and beginning antibiotic treatment.

On 7/12/2024 at 12:50 pm in a phone interview

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F 690	Continued From page 13 with Physician #1, he explained with the antibiotic stewardship program, antibiotics were not ordered when Resident #73 complained of burning with urination on 5/18/2024. He stated he was waiting for the urinalysis to confirm Resident #73 had a urinary tract infection and the culture and sensitivity report to ensure Resident #73 would receive the correct antibiotic for the urinary tract infection. He stated he reviewed the results of the urinalysis from the specimen sent on 5/21/2024 on 5/22/2024 and did not order antibiotics until 5/23/2024 when the culture and sensitivity results were available also. He stated Resident#73 received one course of antibiotics and did not require further treatment for the urinary tract infection.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure there was a physician order for the use of supplemental oxygen (Resident #197) and failed to post signage indicating the use of oxygen outside residents' rooms (Resident #197 and Resident #196) for 2 of 3 residents reviewed for oxygen use.	F 695	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	8/12/24

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F 695	Continued From page 14 Findings included: 1. Resident #197 was admitted to the facility on 7/3/2024 with diagnoses including pneumonia and congestive heart failure. Resident #197's baseline care plan indicated oxygen therapy was required and a goal to not have signs or symptoms of poor oxygen absorption that was dated 7/4/2024. Interventions included observing for and reporting sign and symptoms of respiratory distress to the physician and providing extension tubing or portable oxygen equipment for ambulation as needed. The physician progress note dated 7/4/2024 recorded Resident #197 was receiving 2 liters per minute of oxygen. On 7/8/2024, there was no physician order for the use of oxygen located in Resident #197's medical record. On 7/8/2024 at 10:11 am, Resident #197 was observed lying in bed receiving oxygen at 2 ½ liters per minute via nasal cannula. There was no oxygen signage observed outside Resident #197's door indicating oxygen was in use. On 7/9/2024 at 1:07 pm in an interview with Nurse Aide (NA) #1, she stated there was not a red (oxygen in use) sign on Resident #197's door indicating oxygen was in use. She stated it was the nurse's responsibility when Resident #197 was admitted to gather and post an oxygen in use sign outside Resident #197's door when gathering the oxygen regulator. She stated she did not know why the oxygen in use sign was not	F 695	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 The facility failed to ensure there was a physician order for the use of supplemental oxygen and failed to post signage outside the resident's room for 2 of 3 residents for ordered oxygen use. Corrective action for resident(s) affected by the alleged deficient practice: 1. For resident #197, on 07/09 /24 an order was obtained from the physician for the use of supplemental oxygen. On 07/ 09/24 oxygen signage was placed outside of resident #197's room. For resident # 196 oxygen signage was placed outside the room on 07/9/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 08 / 06/2024 the Director of Nurses/Assistant Director of Nurses completed an audit of all current residents receiving Oxygen Therapy to ensure that all residents receiving supplemental oxygen had a physician order in place for use of supplemental oxygen. The results included: No concerns were identified. On 8 / 06/2024 the Director of Nurses/ Assistant Director of Nurses audited all resident receiving ordered supplemental oxygen for the presence of oxygen signage outside of each resident's room.	

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outside on Resident #197's door and said extra oxygen in use signs were stored in the nurse aide supply room.

On 7/9/2024 at 1:20 pm in an interview with Nurse #2, she stated Resident #197 was receiving oxygen therapy and should have an oxygen in use sign outside the door, and she could not recall whether Resident #197 had the oxygen in use sign outside the door, She said nurses and nurse aides both had access to the oxygen in use signage and were responsible for ensuring an oxygen in use signage was posted outside Resident #197's door.

On 7/9/2024 at 1:56 pm in an interview with Central Supply, she stated Nurse #1 was responsible for placing oxygen signage that communicated no smoking oxygen in use, outside residents' doors when conducting the admission and did not realize Resident #197 did not have an oxygen in use sign outside on the door.

On 7/9/2024 at 1:14 pm in an interview with Nurse #1, she explained it was the assigned nurse, central supply or herself (Nurse #1) responsibility to place the oxygen in use sign outside Resident #197's door prior or on admission. She stated ensuring oxygen in use signage was outside Resident #197's door was one of her duties, and she had been too busy with other tasks to check that an oxygen in use sign was outside Resident #197's door.

On 7/9/2024 at 1:27 pm in an interview with the Administrator, she explained there had not been a constant Lead Nurse, the person who was responsible on admission for placing the oxygen

F 695

The results included: No concerns were identified.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 8/06/2024, the Director of Nurses/ Assistant Director of Nurses began education to all full time, part time, and PRN Nurses (including agency) on the following:

- All residents who require the use of supplemental oxygen must have an active physician order in place.
- All residents who have ordered supplemental oxygen must a have oxygen signs in place outside of their room indicating that oxygen is in use.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. As of 8/11/2024 any nursing staff who does not receive scheduled in-service training 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.

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F 695	Continued From page 16 in use signage outside Resident #197's door. She stated Nurse #1 was acting as Lead Nurse and she had not decided who would assume the responsibility for ensuring oxygen signage was outside residents' doors at this time. The admission Minimum Data Set (MDS) assessment with an admission reference date (ARD) of 7/10/2024 was recorded as in progress and was incomplete. In a follow up interview with Nurse #1on 7/11/2024 at 3:45 pm, she stated there should have been an order entered for oxygen in Resident #197's medical record when admitted to the facility. She explained all nurses could enter physician's orders. She said the facility had standing orders for oxygen, and nurses could call the physician for an order for oxygen as needed. She explained the admitting nurse, who was usually her (Nurse #1), was responsible for ensuring Resident #197 had an order for the use of oxygen. She stated she could not recall completing Resident #197's admission assessment, and there was no order for oxygen on Resident # 196's medical record until 7/9/2024 when it was brought to her attention. On 7/12/2024 at 9:07 am in an interview with the Director of Nursing, she stated there should have been an order for the use of oxygen in Resident #197's medical record and an oxygen in use sign outside Resident#197's door. She said Nurse #1 and/or the nurses assigned to Resident #197 should have ensured there was an order on Resident #197's medical record, and a sign for oxygen in use was outside Resident #197's door to communicate no smoking oxygen was in use.	F 695	The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor that residents receiving oxygen have a physician order in place and have oxygen signage posted outside of their room. Reports 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 or until deemed not necessary for compliance with ADL Care. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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2. Resident #196 was admitted to the facility on 7/2/2024 with diagnoses including pneumonia and chronic obstructive pulmonary disease (COPD).

Resident #196's baseline care plan dated 7/2/2024 included a focus for COPD, and interventions included administering oxygen therapy as ordered by the physician.

There was a physician order dated 7/5/2024 for Resident #196 to received oxygen at 3 liters per minute continuously via nasal cannula every shift for oxygen supplement.

A review of Resident #196's July 2024 Medication Administration Record (MAR) recorded Resident #196 receiving oxygen at 3 liters per minute daily every shift since admission.

On 7/8/2024 at 9:58 am, Resident #196 was observed wearing oxygen 3 liters per minute via nasal cannula. There was no signage communicating oxygen was in use no smoking observed outside Resident #196's door.

The admission Minimum Data Set (MDS) assessment with an admission reference date (ARD) 7/9/2024 was recorded as in progress and was incomplete.

On 7/9/2024 at 1:02 pm in an interview with Nurse Aide (NA) #2, she explained nurses assigned to Resident #196 were responsible for placing oxygen in use no smoking signs outside Resident #196's door. She stated the oxygen in use signs were stored in the medication room with the oxygen tanks. She said she didn't know

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why there was no signage for oxygen in use outside Resident #196's door.

On 7/9/2024 at 1:20 pm in an interview with Nurse #2, she stated there should have been an oxygen in use no smoking sign outside Resident #196's door because she was receiving oxygen continuously. She explained she realized that morning Resident #196 did not have an oxygen in use sign outside on the door but Resident #196 was not in her room and she (Nurse#2) forgot to return to Resident #196's room with a no smoking, oxygen in use sign to place outside Resident #196's door.

On 7/9/2024 at 1:56 pm in an interview with Central Supply, she stated Nurse #1 was responsible for placing the signage that communicated no smoking oxygen in use, outside residents' doors when conducting the admission and did not realize Resident #196 did not have an oxygen in use sign outside on the door.

On 7/9/2024 at 1:14 pm in an interview with Nurse #1, she explained it was the assigned nurse, central supply or herself (Nurse #1) responsibility to place the oxygen in use sign outside Resident #196's door prior or on admission. She stated ensuring oxygen in use signage was outside Resident #196's door was one of her duties, and she had been too busy with other tasks to check that the oxygen in use sign was outside Resident #196's door.

On 7/9/2024 at 1:31 pm in an interview with the Director of Nursing, she stated there should have been a no smoking, oxygen in use sign posted outside Resident #196's door.

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F 695	Continued From page 19 On 7/9/2024 at 1:27 pm in an interview with the Administrator, she explained there had not been a constant Lead Nurse, the person who was responsible on admission for placing the oxygen in use signage outside Resident #196's door. She stated Nurse #1 was acting as Lead Nurse and she had not decided who would assume the responsibility for ensuring oxygen signage was outside residents' doors at this time.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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, staff interviews, and interview with Dialysis Center Nurse, the facility failed to maintain ongoing communication with the dialysis treatment center for 1 of 1 resident reviewed for dialysis (Resident #69). The findings included: Resident #69 was admitted to the facility on 6/10/2024 with diagnoses including end stage renal disease. An active physician order dated 6/11/2024 stated Resident #69 received dialysis on Tuesday, Thursday and Saturday at the local dialysis center.	F 698	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. F698 The facility failed to maintain ongoing communication with the dialysis treatment center for resident #69. 1. Corrective action for resident(s)	8/12/24

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F 698	Continued From page 20 The care plan dated 6/12/2024 indicated Resident #69 was scheduled to receive hemodialysis three times per week due to renal disease with risk for complications: infection, fluid imbalances and hemorrhage from dialysis vascular access port and renal failure. Interventions included checking Resident #69 frequently after any bleeding episodes to ensure no further bleeding, observing, documenting and reporting any signs of infection to the access site and assisting Resident #69 with transfers, walking after returning from dialysis treatments. The admission Minimum Data Set (MDS) assessment dated 6/16/2024 indicated Resident #69 was cognitively intact and was receiving dialysis. A review of Resident #69's dialysis communication notebook on 6/9/2024 at 3:30 pm revealed 8 out of the 13 dialysis communication forms in the notebook were not completed by the facility staff prior to dialysis treatment for Resident #69 since admission to the facility (6/13/2024, 6/18/2024, 6/27/2024, 6/29/2024, 7/2/2024, 7/4/2024, 7/6/2024 and 7/9/2024.) The 8 dialysis communication forms did not have the following information recorded from the facility: pre-dialysis vital signs, weight, vascular access or information shared with dialysis center. There were blank dialysis communication forms in Resident #69's dialysis communication notebook. On 7/6/2024, the post dialysis information on the communication form from the dialysis center requested a current list of Resident #69's medications to be sent on the next dialysis day (7/9/2024). On 7/9/2024 post Resident #69's dialysis treatment, the dialysis center communicated with the facility to send a list of	F 698	affected by the alleged deficient practice: For resident # 69 the facility portion of the dialysis communication sheet was completed by the assigned nurse prior to going for dialysis treatment on 7 / 11/2024. The information included the resident's pre-dialysis vital signs, weight and vascular access. On 7 / 11 /2024 a current list of medications for resident # 69, was faxed to the requesting dialysis center. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents receiving dialysis have the potential to be affected by this alleged deficient practice. On 8 / 7 /2024, the Director of Nursing and nursing team began auditing 100% of dialysis residents to ensure that the facility portion of the dialysis communication sheet for all residents receiving dialysis, was completed prior to being sent for dialysis treatment. The results included: Dialysis communication sheets are being completed prior to resident leaving the facility. On 8 / 7/2024 all residents receiving dialysis were audited by the Director of Nurses/Assistant Director of Nurses to assure that any requested information communicated by the dialysis center had been submitted to the dialysis center. This was completed by a review of their dialysis communication sheets and book for the last 14 days. The results included: No further MARS or other information had been requested from the dialysis center.	

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F 698	Continued From page 21 Resident #69's current medications on a yellow post-it note observed on the outside of Resident #69's dialysis communication notebook. On 7/9/2024 at 3:55 pm in an interview with Nurse Aide (NA) #2, she stated she was responsible for ensuing Resident #69 was dressed, received breakfast and obtain vital signs before leaving for dialysis, and she couldn't recall obtaining pre-dialysis vital signs on Resident #69 on 7/9/2024. NA #2 could not state a reason why Resident #69's vital signs were not obtained. On 7/9/2024 at 3:43 pm in an interview with Nurse #2, she stated when she went to give Resident #69's morning medications on 7/9/2024, a local transportation company had arrived and already taken Resident #69 to the dialysis center. She said she had not completed the dialysis communication form, sent a current list of medications for Resident #69's or administered Resident #69's morning medications on 7/9/2024 prior to Resident #69 going to the dialysis center. She stated she thought Resident #69's scheduled dialysis days had changed to Monday, Wednesday and Friday. When Nurse #2 checked the physician order, she stated Resident #69 was scheduled to receive dialysis on Tuesday, Thursday and Saturday. On 7/11/2024 at 11:54 pm in a phone interview with the Dialysis Center Nurse, she stated the nursing staff at the facility were not completing the dialysis communication forms that communicated vital signs and changes in Resident #69 to the dialysis center prior to Resident #69 receiving dialysis treatments. She said the dialysis center had requested twice on 7/6/2024 and 7/9/2024 for the facility to send a list	F 698	This was completed on 8/7/2024 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/06/2024, the Director of Nurse/Assistant Director of Nurses began education of all full time, part time, as needed (PRN) nurses and agency nurses on the following: Dialysis Communication Process This in-service included the following topics: • The dialysis communication form facility portion is to be completed prior to the resident being sent for dialysis treatment. The pre-dialysis vital signs, weight and vascular access are to be included on the communication form and to be sent each time the resident is sent for dialysis. • Upon return from dialysis the nurse is to review the communication sheet sent back from dialysis to assure that requested information is followed up on timely. Any information needed by the dialysis center should be sent timely by the nurse assigned. Any information sent should be documented as being sent and information sent. The Director of Nursing will ensure that any nurse who has not received this training by 08/11/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 698	Continued From page 22 of Resident #69's current medications, and the facility had not sent the medication list to the dialysis center. She stated the dialysis center had not spoken to anyone specifically at the facility about the nursing staff not completing the communication form or the medication list. On 7/9/2024 at 5:40 pm in an interview with the Director of Nursing, she stated the nurse assigned to Resident #69's was responsible for completing the dialysis communication form that included vital signs and any pertinent information prior to Resident #69's leaving the facility for a dialysis treatment, and Resident #69's dialysis pre-dialysis communication form should had been completed on 7/9/2024 and a current list of Resident #69's medications sent as requested.	F 698	all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 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 F698 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor compliance with the dialysis communication process an follow up for all dialysis residents. Reports 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 Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 755 SS=D	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	F 755		8/12/24

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F 755	Continued From page 23 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 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and a pharmacist interview, the facility failed to document the return of a discontinued medication, Hydroxyzine HCl (an antihistamine used to help control anxiety or symptoms of itching) to the pharmacy for 1 of 1 resident (Resident #73) reviewed for the provision of pharmacy services. The findings included:	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	

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F 755	Continued From page 24 Resident #73 was admitted to the facility on 5/14/2024. A physician order for Hydroxyzine HCl 25 milligrams (mg) every six hours as needed for anxiety or itching for 14 days was written on 5/29/2024. A review of the pharmacy 's medication packing slips for proof of delivery to the facility indicated ten tablets of Hydroxyzine HCl 25mg were delivered to the facility for Resident #73 on 5/29/2024 and on 6/5/2024 for total of 20 tablets dispensed from the pharmacy. A review of the May and June 2024 Medication Administration Record (MAR) recorded Hydroxyzine HCl 25mg was administered to Resident #73 for a total of seven doses on the following dates: - 5/31/2024 at 9:36 pm. - 6/3/2024 at 10:06 pm. - 6/4/2024 at 10:59 pm. - 6/5/2024 at 9:34 pm. - 6/7/2024 at 8:54 pm. - 6/9/2024 at 9:38 pm. - 6/11/2024 at 9:14 pm. There was no documentation on a medication return to pharmacy form that accounted for the remaining 13 tablets of Hydroxyzine 25 mg when the physician order was automatically discontinued after 6/11/2024. In an interview with Nurse #4 on 7/12/2024 at 11:14 am, she stated Resident #73's Hydroxyzine HCl 25 mg tablet was discontinued after the fourteen days per physician order and stated she did not know when Resident #73's discontinued	F 755	corrected by the dates indicated. F755 The facility failed to document the return of discontinued medication for 1of 1 resident. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #73 discharged from facility on 7/30/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents who receive medications have the potential of being affected by the alleged deficient practice. On 08/ 6 /2024 the Director of Nurses audited medications discontinued for the last 14 days for documentation of the discontinued medication being documented as returned on the pharmacy medication return form. The results included: Medications that had been discontinued were not noted to be on the cart. Medications had been return to pharmacy per policy. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/06/2024, the Director of Nurses/Assistant Director of Nurses initiated education on the pharmacy medication return process for all Licensed Nurses (RN's and LPN's), Medication Aides, Full Time, Part Time, as needed, and agency nurses on the following education: Topics included: • Return of Medication. Unused,	

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F 755	Continued From page 25 Hydroxyzine HCl medication was returned to the pharmacy. She explained discontinued medications still in bubble packs were placed in an open box labeled return to pharmacy in the locked medication room and were picked up by the pharmacy at night. She stated the night nurse, assistant Director of Nursing or the Director of Nursing completed the return to pharmacy form listing all the medications in the return to pharmacy box that were picked up by pharmacy nightly. In an interview with the Assistant Director of Nursing on 7/12/2024 at 1:06 pm, she stated the facility did not have a return to pharmacy form indicating Resident #73's Hydroxyzine HCl was returned to the pharmacy after the medication was discontinued after 6/11/2024. She explained due to unavailability of carbon copy return to pharmacy forms in the pharmacy, the facility had not been able to obtain carbon copy return to pharmacy forms and copying the original return to pharmacy form was necessary for the facility's records. She explained sometimes the original return to pharmacy form was not copied and the original copy was sent to the pharmacy. In an interview with the Director of Nursing (DON) on 7/12/2024 at 11:26 am, she stated the nursing staff were to complete the return to pharmacy form when returning discontinued medications to the pharmacy. She explained nursing staff should have removed Resident #73's discontinued medication, Hydroxyzine HCl, from the medication cart, placed the medication in the return to pharmacy box in the locked medication room and completed the return to pharmacy form for pharmacy to pick up. She stated the pharmacy	F 755	discontinued medications and controlled substance should be returned via the McNeill's Long-Term Care delivery person. Medications for hospitalized patients should be kept by the facility for at least 30 days before returning to the pharmacy. Controlled medications should be packaged in a separate return box from the non-control medications. Any returned medication must be written up on a Drug Return Form. Controlled medications and non-controlled medication must be listed on separate forms. Please completely fill out your forms before returning them. • It is the responsibility of the facility staff to properly write up medications to be returned to our pharmacy, paperwork must be signed and dated. All discontinued medications should be written up and returned to our pharmacy at least once weekly. ` • Discontinued medications are to be removed from the medication timely to prevent the potential of a medication error as a result of a discontinued medication being administered after the medication has been discontinued. All education for current staff will be completed by 08/11/2024. 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 nurses and as needed staff. This in-service will be incorporated into the new employee facility orientation.	

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F 755	Continued From page 26 and the facility did not have documentation on a return to pharmacy form that Resident #73's discontinued Hydroxyzine HCL medication had been returned to the facility. The DON was not able to explain what happened to the unaccounted 13 tablets of Resident #73's Hydroxyzine HCl tablets after the physician order was discontinued on 6/11/2024. In a phone interview with Pharmacist #1 on 7/12/2024 at 1:34 pm, he stated Hydroxyzine HCl 25 mg for Resident #73 was discontinued after the 14th day (6/11/2024) based on the physician's order, and the pharmacy had no documentation on a return to pharmacy form that Resident #73's discontinued medication, Hydroxyzine HCl 25 mg tablet, was returned to the pharmacy. He explained there was no time frame in returning discontinued medications to the pharmacy, and the facility usually kept discontinued medications until the physician made a decision not to reorder the medication. He stated discontinued medications returned to the pharmacy were listed on a return to pharmacy form and discontinued medications were picked up six days a week Monday through Saturday. He explained the return to pharmacy form was a carbon copy: one copy was sent with the medications returned to the pharmacy and one copy was maintained at the facility for documentation of the returned medications to the pharmacy. He stated it was the facility's responsibility to request the return to pharmacy forms from the pharmacy and he could not recall a period of time not having the return to pharmacy forms available for the facility. Pharmacist #1 further stated the pharmacy did not track the number of medications dispensed, administered and returned except for controlled medication, and Hydroxyzine HCl was not a	F 755	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/designee will monitor compliance utilizing the Quality Assurance Tool for the Return of Discontinued Medications to the Pharmacy Process. Monitoring of documentation of the return of discontinued medications utilizing the Pharmacy Mediation Return Form will be completed for a sample of 5 residents. Audits will be completed weekly x 2 weeks then monthly x 3 months or until resolved. Reports will be presented to the weekly Quality Assurance Performance Improvement 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 Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager and Dietary Manager.	

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F 755	Continued From page 27 controlled medication.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		8/12/24

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F 758	Continued From page 28 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement monitoring for the side effects for a resident receiving antipsychotics (medications used to treat mental disorders) for 1 of 5 residents reviewed for unnecessary medications (Resident #197) The findings included: Resident #197 was admitted to the facility on 7/3/2024 with diagnoses including dementia, depression and anxiety. Resident #197's baseline care plan dated reviewed on 7/4/2024 included the use of antipsychotic medications. Interventions included performing an Abnormal Involuntary Movement Scale (AIMS), a scale that measures the severity of involuntary movements caused by neuroleptic medications (medications known form their ability to attenuate hallucinations and delusions) assessment and monitoring for side effects of antipsychotics. A review of the active physician orders recorded	F 758	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. F758 The facility failed to implement monitoring of side effects for 1of 5 residents receiving antipsychotic medications used to treat a mental disorder. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 7 / 11 /2024 orders for side effect monitoring were entered for resident # 197 for all ordered antipsychotic medications by the assigned nurse. On 7/23/2024 the resident was	

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Resident #197 was ordered the following medications:
- Lorazepam (an type of antipsychotic used to treat anxiety and sleeping problems) 0.5 milligrams (mg) every four hours as needed for agitation for 14 days on 7/4/2024.
- Haloperidol (an antipsychotic medication used to treat mental disorders) 0.5mg every four hours as needed for agitation until 7/16/2024 on 7/4/2024.
- Risperidone (a type of antipsychotic medication that teats mental health conditions) 0.5mg once a day for agitation on 7/3/2024.
- Quetiapine Fumarate (antipsychotic medication that treats several kinds of mental health conditions) 25 mg 1/5 tablet every evening for agitation on 7/3/2024.

A physician progress note dated 7/4/2024 recorded Resident #197's psychological history included anxiety, depression, dementia, agitation, delusions and hallucinations.

A pharmacy review of Resident #197's medications was conducted on 7/4/2024. The pharmacy recommendation requested a diagnose for the medications Risperdal, Seroquel and Haldol which had not completed the recommendation process at the facility at this time.

A psychoactive medication interventions consent dated 7/6/2024 listed Quetiapine Fumarate, Risperidone and Haloperidol as medications used to treat Resident #197's agitation.

There was no AIMS assessment located in Resident #197's medial record.

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discharged to home.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
All residents who receive medications have the potential of being affected by the alleged deficient practice.

On 08/ 6 /2024 the Director of Nurses/Assistant Director of Nurses audited all residents with ordered antipsychotic medications for the presence of an order to monitor the medication's side effects. The results included: Batch orders were noted to be present for antipsychotic medications' side effects and behaviors.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 08/06/2024, the Director of Nurses/Assistant Director of Nurses initiated education on the side effect order monitoring of antipsychotic medications for all Licensed Nurses (RN's and LPN's), Medication Aides, Full Time, Part Time, as needed, and agency nurses on the following :
Topics included:
- Residents with an ordered antipsychotic medication are to have side effect monitoring orders in place for each shift.
- Residents with an ordered antipsychotic medication are to have an order in place to monitor the behaviors targeted to that medication for each shift.
- The medications include ordered:

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A review of the July 2024 Medication Administration Record (MAR) reported Resident #197 had received Risperidone 0.5mg daily since 7/4/2024 and Quetiapine Fumarate 25 mg 1/5 tablet every evening since 7/3/2024. There was no documentation that Resident #197 had received a dose of Lorazepam or Haloperidol. Resident #197's July 2024 MAR further reported the monitoring to indicate the number of antipsychotic side effects every shift was discontinued on 7/3/2024.

There was no nursing documentation indicating Resident #197 exhibited any psychological behaviors since admission.

The admission Minimum Data Set (MDS) assessment dated with an admission reference date (ARD) of 7/10/2024 was recorded in process and was incomplete.

In an interview with Nurse #1 on 7/11/2024 at 3:55 pm, she explained when Resident #197 was admitted on 7/3/2024, the order to monitor for antipsychotic medication side effects from a previous admission in May 2024 was still listed on the electronic MAR. She stated she had to discontinue the order to monitor of antipsychotic side effects from the previous admission in May 2024 before she could activate a new batch order that included the monitoring of antipsychotic side effects. She stated she did not reactivate a new batch order for Resident #197 who was receiving antipsychotic medications and could not give an explanation why she did not activate the batch order for antipsychotics for Resident #197 on the electronic MAR. Nurse #1 further stated an AIMS assessment that was usually conducted by the nursing staff had not been completed at this time

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antidepressants, antianxiety medications and antipsychotic medications.

- The presence or absence of either side effects or a targeted behavior(s) are to be indicated on the electronic medical record by the number occurring each shift.
- Additional documentation of behaviors may be needed in the progress notes as well as notification of the physician/responsible party.

All education for current staff will be completed by 08/11/2024. 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 nurses and as needed 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/designee will monitor compliance utilizing the Quality Assurance Tool for the Antipsychotic Medication Side Effect Process for compliance with the order process. Audits will be completed weekly x 2 weeks then monthly x 3 months or until resolved. Reports will be presented to the weekly Quality Assurance Performance Improvement committee by the Administrator or Director of Nurses to

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LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 31 for Resident #197. She explained usually in morning clinical meetings will catch when AIMS assessment had not been completed but due to Resident #197 admission prior to a holiday and the weekend, the facility had not held a morning clinical meeting to discuss Resident #197's need for an AIMS assessment. In an interview with the Director of Nursing on 7/12/2024 at 9:11 am, she stated due to Resident #197 receiving the antipsychotics, Risperidone and Quetiapine Fumarate daily, the nursing staff should complete an AIMS assessment and monitor for and document on the MAR side effects of the antipsychotics. She explained when antipsychotics were ordered by the physician, there was a batch of orders for nurses to activate that included the monitoring and documentation for antipsychotic medications that was not activated for Resident #197. She stated morning clinical meeting had not been held due to a holiday prior to the weekend to ensure AIMs assessment had been completed since Resident #197's admission on 7/3/2024.	F 758	ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager and Dietary Manager.	