STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING ______ B. WING ______	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	**121 RACINE DRIVE WILMINGTON, NC 28403**

(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
E 000	Initial Comments The survey team entered the facility on 1/06/25 to conduct a recertification and complaint investigation survey and exited on 1/09/25. Additional information was obtained remotely on 01/22/25. Therefore, the exit date was changed to 01/22/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OPUB11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 1/06/25 to conduct a recertification and complaint investigation survey and exited on 1/09/25. Additional information was obtained remotely on 01/22/25. Therefore, the exit date was changed to 01/22/25. Event ID# OPUB11. The following complaint intakes were investigated: NC00223312, NC00225225, NC00224927, NC00221505, and NC00225840. 3 of the 13 complaint allegations resulted in a deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		1/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/31/2025

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

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F 584	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility, 1a) failed to remove black greenish substance from the commode base caulking in resident rooms (106,112, 214, 220, 303, and 410), 1b) failed to replace resident's missing florescent overbed light covers in rooms (201A, 201B, 203A, 203B, 207A, 207B, 208A, 208B, 212A, 212B, 214A, 214B, and 215B). These failures occurred on 4 of 4 hallways (100, 200, 300, and 400 Hall) observed for a safe, clean,	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged	

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F 584	Continued From page 2 homelike environment. Findings included: 1a. An initial observation on 01/08/25 at 8:10 AM revealed resident commodes (Rooms: 106, 112, 214, 220, 303, and 410) were noted to have black greenish substance located around the base of the commodes. An interview was conducted on 01/08/25 at 2:00 PM with the Housekeeping Supervisor. The Housekeeping Supervisor stated her staff was responsible for sweeping and mopping residents' rooms daily and the Maintenance Department was responsible for caulking and removing black greenish substances from commode bases. 1b. A follow-up observation on 01/09/25 at 7:30 AM with the Maintenance Director revealed missing florescent overbed light covers in rooms, which were occupied with residents at the time of the observation. (201A, 201B, 203A, 203B, 207A, 207B, 208A, 208B, 212A, 212B, 214A, 214B, and 215B). An interview and observation was conducted on 01/09/25 at 7:45 AM with the Maintenance Director. The Maintenance Director stated there were multiple resident room areas that still needed to be addressed. He stated he did not have an assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes on the 100,200,300 and 400 halls and did not notice resident rooms with missing overhead light covers. He said maintenance was responsible for repairing or replacing items in the facility, including removing blackened substances	F 584	deficiencies cited have been or will be corrected by the dates indicated. F584 Safe Clean / Comfortable / Homelike Environment Corrective action for the failures to the environment, an alleged deficient practice that occurred on 4 of 4 hallways (100, 200, 300, and 400 Halls) observed for a safe, clean, homelike environment. A. The black substance on the commode bases in resident rooms (106, 112, 114,220,303 and 410) immediately cleaned of black substance and recaulking of those stated rooms by Maintenance Director. B. Missing florescent overbed light covers in resident rooms (201A&B, 203A&B, 207A&B, 208A&B, 212A&B, 214A&B and 215B. Corrective action for the identified failures with the potential to be affected by the deficient practice: A. The Maintenance Director audited 100% of resident bathrooms discolored or missing caulking on 1/27/2025. All affected areas identified in the 2567 were corrected by the Maintenance Director on or before January 31, 2025. The other rooms identified during the audit will be completed by 2/14/25. B. The Maintenance Director audited 100% of over bed light covers in resident rooms. The Maintenance Director	

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F 584	Continued From page 3 around commodes and re-caulking, as well as replacing missing fluorescent overbed light covers. No staff had reported to him the black greenish substance around the base of the commodes and no staff had reported to him the missing light covers. A follow-up facility tour was conducted on 01/09/25 at 11:15 AM of the 100 and 200 halls with the Administrator. The tour revealed: black greenish substance around the base of resident commodes and missing fluorescent overbed light covers. He stated the residents' rooms observed in the 100 and 200 halls with commodes that had black greenish substance around their bases and missing fluorescent overbed light covers needed to be addressed by the Maintenance Director. He revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. The Administrator stated it was his expectation for all the residents to have a safe and homelike environment that was clean and in good repair.	F 584	corrected all rooms missing light covers on or before January 31, 2025. Systemic Changes: On 1/28/2025, the Administrator educated the Leadership Team (Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, Support Nurse, Health Information Manager, Activities Director, Dietary Manager, Treatment Medication Aide and Maintenance Director, Housekeeping Supervisor and Maintenance Director) on how to conduct the Environmental Services Focus Rounds. The rounds will be completed weekly and submitted to the administrator for review. Areas identified will be noted on the weekly environmental round sheet with Administrator validation with Maintenance Director of correction. The Leadership Team will complete a work order for the Maintenance Director. The Maintenance Director will review the identified concern and develop a plan to repair or replace the identified concern timely (within 48 hours). The Administrator will inspect the repair or replacement when it is completed and add it to the QA monitoring tool to be reviewed during the next scheduled QA Meeting. Quality Assurance: Beginning January 31, 2025 the Administrator or designee will monitor compliance using the QA tool, Environmental Services Focused Rounds. An audit will be completed of resident specific rooms by each member of the	

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F 584	Continued From page 4	F 584	leadership team (as stated above) weekly for three months. Focused rounding will continue as deemed necessary by the QAPI Committee. Reports will be presented by the Administrator to the Monthly Quality of Life - QA committee and corrective action initiated as appropriate. Date of Compliance: 1/31/25	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and the Nurse Practitioner interviews, the facility failed to comprehensively and effectively assess a resident's skin resulting in a delay in identifying and addressing a large, excoriated area (superficial wound or raw irritated patches with visible marks often caused by scratching, rubbing, or other mechanical trauma) behind the left knee of an immobile resident (Resident #25). The resident had a history of yeast developing in the folds of her skin. This deficient practice occurred for 1 of 1 resident reviewed for non-pressure related skin conditions.	F 684	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.	1/31/25

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F 684	Continued From page 5 Findings included. Resident #25 was admitted to the facility on 11/02/22. The Minimum Data Set (MDS) quarterly assessment dated 12/17/24 revealed Resident #25 was cognitively intact. She exhibited no behaviors and had no rejection of care. She required extensive two-person assistance with activities of daily living. Her weight was 240 pounds. A care plan revised 12/19/24 revealed Resident #25 had the potential for impaired skin integrity and was at risk for pressure ulcer development related to limited mobility and incontinence. Interventions included in part to report to the nurse immediately if redness, open areas, or skin irritation, and complete weekly full body skin assessments. A weekly skin evaluation documented by Nurse #5 dated 01/04/25 for Resident #25 revealed no new skin issues. During a phone interview on 01/09/25 at 12:00 PM Nurse #5 who completed the most recent weekly skin assessment dated 01/04/25 stated she typically completed the skin evaluations during the time the nurse aides were providing personal care. She stated she could have missed the excoriation on Resident #25's legs and abdomen because she just did a quick glance during her assessment. She stated she should not have rushed through the assessment. A Nursing Report Sheet (paper with written	F 684	F684 The facility failed to comprehensively and effectively assess a resident’s skin resulting in a delay in identifying and addressing a skin concern. 1. Corrective action for resident(s) affected by the alleged deficient practice: 1/8/2025, the Wound Nurse completed skin assessment for resident #25. MD was notified of excoriation behind left knee and treatment orders were obtained and treatment completed. On 1/30/2025 the DON re-educated Nurse #7 on Skin and wound UDA accuracy and timely completion and notification for timely treatment of skin concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 1/21/2025 - 1/23/2025 the DON completed 100% of current residents to ensure there was a Weekly Skin check in place to identify any new skin conditions including rashes, MASD. The results included: 78 of 78 skin assessments were in compliance. On 1/23 /25, the DON and Unit Managers, completed 100% skin assessment of current residents to ensure no new areas of concerns were present. The results included: no new concerns were noted. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2025, the DON began education	

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F 684 Continued From page 6

comments used by the nurse to report information regarding residents to the oncoming shift. It is not a part of the residents medical record) initially dated 01/06/25 but then crossed through and dated 01/07/25 revealed a note that Resident #25 had a left leg rash and rawness behind the left knee. The Director of Nursing (DON) reported this was documented by Nurse #7.

During a phone interview on 01/22/25 at 4:20 PM Nurse #7 stated on the morning of 01/08/25 at approximately 6:30 AM, just before the end of her shift, Resident #25 had complaints of itching and burning to her left leg. She stated she observed a large red area behind the left knee, and she thought it was a rash. She reported this to Nurse #1, the oncoming nurse during end of shift report at approximately 6:45 AM. She stated Nurse #1 told her that she would notify the Wound Nurse and the Nurse Practitioner or Physician and make a note in the resident's medical record. She reported that she typically was not assigned to Resident #25 and did not know how long the rash could have been there.

Review of Resident #25's progress notes from 01/01/25 through 01/08/25 was completed on 01/08/25 at 10:30 AM and revealed no documentation of any skin irritation.

During an interview and observation conducted on 01/08/25 at 10:45 AM, Resident #25 was observed lying in bed. She was alert and oriented to person, place, and time. She complained of left knee pain. Nurse #1 was notified and entered Resident #25's room to evaluate. A large, excoriated area that appeared red and irritated was noted behind her left knee. Resident #25

F 684

of all FT, PT, PRN and Agency Nurses on Skin and wound UDA accuracy and timely completion and notification for timely treatment of skin concerns. 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. Any staff that has not received scheduled in-service training will not be allowed to work until training has been completed by 1/30/25

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 and/or designee will monitor 5 residents for accurate and complete skin assessments, documentation is complete in medical record with timely notification of MD and timely initiation of treatment of newly identify skin concerns. Monitoring of 5 residents will be completed weekly for 2 weeks and then monthly x 3 or until resolved. Reports will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator,

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F 684	Continued From page 7 stated the area behind her knee had been there for a month. She stated the nurses were aware but there had been no medications applied to the area. Resident #25 stated she didn't know what caused the area to be red and inflamed. Further observation of Resident #25 revealed she had excess skin folds hanging from her abdomen and thighs. Resident #25 stated she had gained a lot of weight and due to her excessive skin folds she relied on staff to check her skin between the large skin folds to determine if there were any concerns. She stated she would not refuse allowing staff to perform skin assessments in case she needed any type of treatment for her skin. During an interview on 01/08/25 at 10:50 AM Nurse #1 stated she was the assigned nurse. She indicated she was not aware that Resident #25 had excoriation behind her left knee. She stated she would notify the Wound Nurse. During a follow up phone interview on 01/22/25 at 4:15 PM Nurse #1 stated she was not made aware of the excoriated area behind Resident #25's left knee during shift change report on the morning of 01/08/25. She stated that had she been made aware she would have notified the Wound Nurse and Physician sooner so that treatment orders could be implemented. During an interview on 01/08/25 at 11:05 AM the Wound Nurse stated she was not aware of the excoriated area behind Resident #25's left knee until now. She did not say when the last time she had evaluated Resident #25, but she only evaluated residents when the nurses informed her of any skin concerns. The Wound Nurse stated the area behind the left knee had not been	F 684	Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/31/2025	

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F 684	Continued From page 8	F 684		

there for a month as indicated by Resident #25. She stated she would notify the Nurse Practitioner and implement treatment orders.

A progress note dated 01/08/2025 at 11:07 AM for Resident #25 documented by the Wound Nurse revealed open excoriation was noted to the left leg folds. The physician was notified, and new orders were received.

A physician's order dated 01/08/25 for Resident #25 revealed Nystatin external ointment 100000 units (antifungal). Apply to left leg folds topically every day and night shift for candida (fungal infection caused by an overgrowth of yeast).

A skin evaluation form dated 01/09/25 documented by the Wound Nurse revealed Resident #25's left leg was noted with a red papular rash (solid raised bumps on the skin) behind the left knee with open excoriation noted at the crease of the left knee. The area behind the left knee measured 18 centimeters (cm) x 6 cm. The physician was notified, and an antifungal medication was applied to the area.

During an interview on 01/09/25 at 12:42 PM the Nurse Practitioner stated she evaluated Resident #25 yesterday 01/08/25 after being notified of the excoriated skin condition. She implemented treatment orders at that time. She reported Resident #25 had large skin folds due to her weight and had issues before with yeast developing in the folds of her skin. She stated the nurses should be doing thorough skin assessments weekly to identify any issues or concerns so that treatment orders could be initiated promptly.

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F 684	Continued From page 9 During an interview on 01/09/25 at 1:00 PM the Director of Nursing (DON) stated Nurse #7 the night shift nurse identified the excoriation to Resident #25's knee on 01/06/25. She stated Nurse #7 made a handwritten note on the end of shift report sheet and wrote rash behind left knee but no description or measurements. She stated Nurse #7 did not document the area anywhere in the medical record. She stated the area should have been passed along in report the following morning and documented in the medical record. She indicated it should have been communicated to the Wound Nurse or to the Nurse Practitioner so that treatment could have been initiated sooner. She stated thorough skin assessments should be conducted and documented by the nurses and the Nurse Practitioner or Physician notified promptly for treatment orders. She indicated education would be provided. During a follow up phone interview on 01/22/25 at 4:30 PM the Director of Nursing stated upon further investigation, Nurse #7 stated to her that the area behind Resident #25's left knee was reported to Nurse #1 during shift report on the morning of 01/08/25. She indicated education would be provided regarding conducting thorough skin assessments and identifying and addressing any concerns.	F 684		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician, and the	F 760	The statements made on this plan of	1/31/25

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F 760	Continued From page 10 Consultant Pharmacist interviews the facility failed to prevent significant medication errors by administering Resident #223 the incorrect dose of a blood pressure medication, Losartan 50 milligrams (an antihypertensive), and administering blood pressure medications without following the physician's ordered parameters to hold the medication (Residents #223 and #47). This resulted in Resident #223 experiencing hypotension (low blood pressure) and symptoms of head pressure, neck pain, and nausea. There was no significant outcome for Resident #47. This deficient practice occurred for 2 of 2 residents reviewed for medication administration. Findings Included. 1.) Resident #223 was admitted to the facility on 07/19/24 with diagnoses including hypertension. The Minimum Data Set (MDS) admission assessment dated 07/21/24 revealed Resident #223 was cognitively intact. A physician's order dated 07/23/24 for Resident #223 revealed Losartan 50 milligram tablets. Give via PEG (percutaneous endoscopic gastrostomy) tube at bedtime for hypertension. Hold if systolic blood pressure is less than 140 mmHg (millimeters of mercury). A nursing progress note dated 08/22/24 at 03:19 AM revealed Resident #223 requested to speak with the nurse at approximately 2:30 AM due to complaints of burning sensation, head pressure, neck pain, and nausea. Resident #223's blood pressure was 62/40 mmHg with a manual cuff, and 59/36 mmHg obtained by second nurse with an automatic cuff. His blood pressure was	F 760	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. F760 The facility failed to prevent significant medication errors by administering wrong dose of medication (antihypertensive) and administering blood pressure medications without following the MD ordered parameters to hold medication 1. Corrective action for resident(s) affected by the alleged deficient practice: On 8/21/24, resident #223 was assessed by nurse. MD notified of medication error and orders received for resident to be sent to ER, resident refused to go to the hospital. Resident's BP was monitored by nursing staff. On 8/22/24, order for Losartan 50mg via peg at HS. Hold if SBP less than 140, with supplemental documentation imputed in resident #223 orders in PCC and received from Pharmacy. On 8/23/2024, Nurse #6 was re-educated om Medication Administration by the DON.	

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F 760	Continued From page 11 obtained again manually and was 62/40 mmHg and the second nurse obtained a reading of 65/45 mmHg manually. Resident #223's oxygen saturation was maintained around 95% and dropped as low as 82% with pulse oximetry. The physician was called and gave orders to have the resident sent out to the hospital for evaluation for low blood pressure. Resident #223 stated he didn't want to go to the hospital, but the physician insisted on calling the ambulance for further evaluation. Emergency Medical Services (EMS) arrived, and his blood pressure was 95/60 mmHg and pulse oximetry at 95%. His heart rate and temperature were within normal limits. EMS staff asked if the resident wanted to go to the hospital for further evaluation and Resident #223 declined. The Physician was made aware. During a phone interview on 01/09/25 at 10:33 AM Nurse #6 stated she was new to the facility at the time of the incident and was still in training. Nurse #6 stated she did give Resident #223 Losartan instead of holding the medication. She stated the blood pressure medication had hold parameters, but no box popped up in his electronic medical record to check the residents blood pressure. She stated that she administered the medication from the card that was in the medication cart. Later Resident #223 became lethargic, complained of headache, and nausea. His blood pressure was low, so they called the physician who instructed them to call 911. EMS arrived soon after. EMS asked if he wanted to go to the hospital, but the resident refused to go. She reported he did not go to the hospital, but they continued to do frequent blood pressure checks with no further complaints of headache or nausea and his blood pressure was trending up. She stated he was discharged home two days	F 760	On 1/8/25, LPN notified MD/RP that Midodrine 2.5mg was administered on 1/2/25 without following ordered hold parameters for resident #47. No significant outcome occurred. MD reviewed resident #47 blood pressures and no order changes were made. On 1/29/2025, Nurse #7 was re-educated om Medication Administration by the DON. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 1/28/2025, the DON completed 100% audit of resident on antihypertensive with parameters, had supplemental documentation for BP on EMAR. Results included: All residents with hold paraments had a supplemental documentation on EMAR to document blood pressures. On 1/28/2025 the DON completed a 100% audit of antihypertensive with orders for hold parameters for the last 7 days for medications not administered per physician orders. Results included: No new errors were discovered. On 1/28/2025 the DON audited the last 14 day of new orders to ensure medication card matches the EMAR. Results included: Three discontinued medications were removed from med carts. From 1/28/2025 to 1/30/2025 the	

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later. She stated the nurse that was orienting her questioned the dose after the resident became symptomatic when she told the nurse that she had administered it to him. She indicated she didn't realize she had given 100 milligrams instead of 50 milligrams, but she should have held the medication anyway according to the prescribed parameters. She indicated she received training on medication administration following the incident.

A progress note dated 08/22/24 at 2:59 PM documented by Unit Manager #2 revealed Resident #223 was administered the right medication, but the wrong dose and the parameters were not followed per the Medication Administration Record. Resident #223's blood pressure dropped. The physician was notified, and actions were taken to improve his blood pressure. He refused to go to the hospital. Resident #223 was examined by the Physician at 8:00 this morning with this nurse present. No further adverse effects were noted. Resident #223 participated in physical therapy this morning and was up in his wheelchair. He and his family member were aware.

During an interview on 01/08/25 at 1:30 PM Unit Manager #2 stated she was made aware of the incident the morning it occurred. Resident #223 was admitted for short term rehab therapy. They discovered that Nurse #6 gave the right medication but the wrong dose during the 9:00 PM medication pass. The order in Resident #223's electronic medical record revealed to administer 50 milligrams of Losartan, but the medication card read to give 100 milligrams. The order was changed from 100 milligrams to 50 milligrams, but the medication card was not

F 760

DON/designee began medication administration observation of nurses and medication aids to audit compliance with following Physician orders and administering medications.

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

On 1/27/2025, the DON and/or designee began education of all FT, PT, and as needed Nurses & Medication aids on Medication administration, 6 rights of medication administration, significant medication errors, and ways to prevent medication errors. 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. Any staff that has not received scheduled in-service training will not be allowed to work until training has been completed by 1/30/25

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 audit 4 nurses and/or medication aids for compliance with medication administration, following physician orders by completing medication administration observations.

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F 760	Continued From page 13 updated because the new order was not sent to the pharmacy. She stated they also discovered that Resident #223's blood pressure recorded during the 9:00 PM medication pass was 117/69 mmHg so the resident should not have received the medication according to the parameters to hold the medication of the systolic blood pressure was less than 140 mmHg. She stated a few hours after receiving the medication around 2:30 AM the resident had complaints of headache and nausea, and his blood pressure was low. Resident #223 refused to go to the hospital, but EMS was called anyway. The resident continued to refuse to be sent out. The physician evaluated him later that morning and the assessment was within normal limits, and he had no further complaints. Resident #223 participated in physical therapy that morning and discharged home within a couple of days. A progress noted dated 08/24/24 at 3:19 PM Resident #223 discharged home with his family. During an interview on 01/08/24 at 1:00 PM the Director of Nursing (DON) stated on 08/21/24 Nurse #6 who was completing new hire orientation was working on the Rehab Hall on the night of the incident. Resident #223 was alert and oriented and called Nurse #6 to the room with complaints of nausea and other symptoms. His blood pressure was checked, and it was low. The physician was notified and ordered Resident #223 to be sent to the hospital for evaluation, but the resident refused to be sent out. EMS was notified to come evaluate and transport him but Resident #223 continued to refuse to go out. EMS also asked the resident if he wanted to go to the hospital, but he continued to refuse. She stated she was notified that morning, and they reviewed	F 760	This monitoring will be completed weekly x 3 weeks and then monthly times 3 months or until resolved. Reports will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 1/31/2025	

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F 760	Continued From page 14 the Losartan medication card. She stated upon investigation they discovered that the Losartan order was changed on 07/23/24 from 100 milligrams to 50 milligrams. Nurse #6 gave 100 milligrams instead of the prescribed 50 milligram tablet. The order was updated in the electronic medical record, but the new order was not sent to the pharmacy. The nurses were still working from the old medication card that had the 100 milligram tablets. She stated the order should have been discontinued altogether and a new order entered for the 50 milligrams and the order sent to the pharmacy. The pharmacy would have sent a new card with the correct dosage and instructions. She stated they also discovered that the medication should have been held due to his systolic blood pressure being less than 140 mmHg, but Nurse #6 administered the medication. During an interview on 01/08/24 at 2:15 PM the Physician stated he was made aware of the medication error when it occurred. He indicated he evaluated Resident #223 following the incident. He stated Resident #223 was on long term antihypertensive therapy. Receiving the extra 50 milligrams would not have any severe outcome and there was no significant outcome regarding Resident #223 receiving Losartan 100 milligrams. He agreed that it was a medication error and stated he expected the nurses to follow the orders and the blood pressure parameters. During a phone interview on 01/09/25 at 1:38 PM the Consultant Pharmacist stated receiving a blood pressure medication when not indicated could cause symptoms such as low blood pressure, dizziness, nausea, and headache.	F 760		

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2.) Resident #47 was admitted on 11/20/24 with diagnoses including hypotension.

The Minimum Data Set (MDS) admission assessment dated 11/25/24 revealed Resident #47 was cognitively intact.

A physician's order dated 12/05/24 for Resident #47 revealed Midodrine (prescribed to treat low blood pressure) 2.5 milligrams. Give 1 tablet by mouth three times a day for hypotension. Hold for systolic blood pressure greater than 95 mmHg (millimeters of mercury).

Review of the Medication Administration Record (MAR) for Resident #47 dated January 2025 revealed on 01/02/25 Midodrine 2.5 milligrams was administered by Nurse #7 at the following times with blood pressure readings as follows:

01/02/25 a 6:00 AM with a blood pressure reading of 120/56 mmHg. (systolic/diastolic)
01/02/25 at 12:00 PM with a blood pressure reading of 120/62 mmHg.
01/02/25 at 5:00 PM with a blood pressure reading of 118/60 mmHg.

During an interview on 01/08/25 at 1:00 PM the Director of Nursing (DON) stated there had been ongoing issues with staff not following medication parameters ordered by the physician. She indicated that according to the MAR, Nurse #7 signed off that the Midodrine was administered to Resident #47 although her blood pressure was outside of the prescribed parameters. She stated Nurse #7, who administered the Midodrine outside of parameters on 01/02/25, was out on medical leave and was unavailable for interview.

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During an interview on 01/08/25 at 2:15 PM the Physician stated he was made aware by Unit Manager #2 of Midodrine being administered outside of parameters to Resident #47 on 01/02/25. He reported that the medication was discontinued today as it was no longer indicated for her. He stated Resident #47 did not have any symptoms or outcome from receiving the medication.

During an interview on 01/09/25 at 1:38 PM the Consultant Pharmacist stated she had identified not following blood pressure parameters in her monthly medication reviews. She reported this in her monthly reports that were sent to the DON. She stated she would work with the DON to help ensure parameters were being followed. She indicated taking Midodrine when not needed would increase the blood pressure unnecessarily, or cause side effects such as dizziness and headaches.

During a follow up interview on 01/09/25 at 1:00 PM, the Director of Nursing stated they had provided education regarding not following physician orders to hold medications according to the prescribed parameters to all nursing staff beginning in August 2024. Education had also been provided verbally to individual staff members between August through December 2024. She stated she had been providing education and conducting audits regarding following medication parameters, but the problem continued. She reported further education and medication audits would be conducted.