

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345215</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>08/22/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>River Trace Nursing and Rehabilitation Center</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 Lovers Lane , Washington, North Carolina, 27889</b>			
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E0000	Initial Comments  An unannounced recertification and complaint investigation survey was conducted 8/18/25 through 8/22/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D3B33-H1.		E0000				
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted from 8/18/25 through 8/22/25. The following intakes were investigated: 2595330, 2593596, 844223, 844224, 844221, 844216, 844217, 844215, 844214, 844212, 844211, 844210, 844209 and 844208.  7 of the 33 complaint allegations resulted in deficiency.  Immediate Jeopardy was identified at:  CFR 483.35 at tag F726 at a scope and severity J  CFR 483.80 at tag F880 at a scope and severity J  Immediate Jeopardy began on 8/20/25 and was removed for F880 on 8/21/25 and for F726 on 8/22/25.  The Statement of Deficiencies was amended on 9/11/25.		F0000				
F0550 SS = D	Resident Rights/Exercise of Rights  CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights.  The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.		F0550				

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0550 SS = D	<p>Continued from page 1</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and staff and resident interviews, the facility failed to treat a resident with dignity and respect when a staff member did not knock or announce their presence before entering a resident's room (Resident #49) and failed to maintain residents' dignity when a resident had an uncovered urinary catheter drainage bag, leaving the urine visible to the public (Resident #7). The reasonable person concept was applied for Resident #7 as individuals have the expectation of being treated with dignity and would not want urine visible to visitors, staff and other residents. This was for 2 of 7 residents reviewed for dignity (Resident #49, Resident #7).</p> <p>Findings included:</p>	F0550					

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F0550 SS = D	<p>Continued from page 2</p> <p>1. Review of Resident #49's Minimum Data Set assessment dated 7/9/25 revealed she was assessed as cognitively intact.</p> <p>During observation on 8/19/25 at 8:08 AM Housekeeper #1 was observed to enter Resident #49's room without knocking or announcing her presence. Resident #49 was in the bed closest the door and the door was fully open during this observation.</p> <p>During an interview on 8/19/25 at 8:10 AM Housekeeper #1 stated if the residents were already awake, she did not need to knock or announce her presence before entering their room but if they were asleep, she knocks.</p> <p>During an interview on 8/19/25 at 8:12 AM Resident #49 stated she would prefer staff knock or announce their presence before entering her room because she liked to know who was in her room and what they were doing.</p> <p>During an interview on 8/19/25 at 2:54 PM the Housekeeping Supervisor stated staff were to always announce their presence before entering a resident's room including if the resident was awake.</p> <p>During an interview on 8/19/25 at 3:03 PM the Administrator stated staff were always to knock or announce their presence prior to entering resident rooms.</p> <p>2. Resident #7 was admitted to the facility on 7/23/25 with diagnoses that included obstructive uropathy and non-Alzheimer's dementia.</p> <p>Resident #7's comprehensive care plan initiated 7/24/25 revealed he required an indwelling urinary catheter.</p> <p>The 5-day Minimum Data Set (MDS) assessment dated 7/29/25 for Resident #7 revealed he was moderately cognitively impaired and had an indwelling urinary catheter.</p> <p>An observation conducted on 8/18/25 at 11:45 AM revealed Resident #7 walked around the day room and a urinary catheter bag which contained urine, hung on the right side of his walker. The urine in the bag was visible. There were several residents, a visitor and staff in the day room.</p>		F0550				

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F0550 SS = D	<p>Continued from page 3</p> <p>An observation was conducted on 8/18/25 at 12:40 PM. Resident #7 was in the day room and a urinary catheter bag hung on the right side of his walker. The urinary catheter bag was one-quarter full of urine and visible to staff, residents and visitors.</p> <p>In an interview with Nurse #1 on 8/18/25 at 12:40 PM she revealed she was not aware a urinary catheter bag should be covered for dignity. Nurse #1 stated she didn't think the facility had privacy bags available for catheter bags.</p> <p>On 8/18/25 at 12:52 PM an interview was conducted with Nurse Aide (NA) #1. NA #1 stated she was assigned to Resident #7 that day. She further stated she had never seen a urinary catheter bag privacy bag on the unit and if he had one it would be in his room, but she didn't see one that morning.</p> <p>A follow-up observation was conducted on 8/18/25 at 4:00 PM. Resident #7 was seated in the day room. His urinary catheter bag hung on the right side of his walker and urine was visible through the bag.</p> <p>In an interview with the Director of Nursing (DON) on 8/19/25 at 1:09 PM she stated all urinary catheter bags should have a privacy cover and that the facility supplied them. The DON indicated the covers were to preserve the dignity of residents with indwelling urinary catheters by keeping the urine hidden from the view of visitors, residents and staff.</p> <p>In an interview with the Administrator on 8/19/25 at 2:11 PM, she stated the facility provided privacy bags to cover urinary catheter bags. She further stated all urinary catheter bags should be covered with a privacy bag. The Administrator indicated the cover was for the resident's privacy and dignity.</p>		F0550				
F0554 SS = D	<p>Resident Self-Admin Meds-Clinically Approp</p> <p>CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.</p>		F0554				

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F0554 SS = D	<p>Continued from page 4 This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and staff and resident interviews, the facility failed to assess a resident's ability to self-administer medications for 1 of 6 residents reviewed for self-administering medications (Residents #101).</p> <p>Resident #101 was admitted to the facility on 3/22/22 with diagnoses that included chronic kidney disease, anxiety, depression and insomnia.</p> <p>Review of Resident #101's quarterly Minimum Data Set assessment dated 6/17/25 revealed Resident #101 was cognitively intact with no delusions, behaviors, or rejection of care.</p> <p>Review of Resident #101's medical record revealed no documentation that Resident #101 had been assessed to self-administer medications.</p> <p>Further review of Resident #101's medical record revealed no care plan for self-administration of medications.</p> <p>An observation of Resident #101 on 8/19/25 at 1:00 PM revealed her to be in her room, sitting on the side of the bed eating her lunch. On Resident #101's overbed tray was a medicine cup that contained 8 pills.</p> <p>An interview with Resident #101 on 8/19/25 at 1:01 PM revealed Medication Aide #1 came in and put the medicine cup with the pills on her tray. Resident #101 went on to say she did not know what the medications were or why she took the medications.</p> <p>An interview with Medication Aide #1 on 8/19/25 at 1:10 PM revealed she always left Resident #101's medication on the overbed tray for the resident to take when she wanted to take them. She also stated she did not know if the resident had been assessed to self-medicate, nor did she know where to locate that information. She went on to say she was aware that it was not good practice, and she should never leave medications unattended in a resident's rooms. She identified the medications left in the room as acyclovir (an antiviral medication used to treat infections) 400 milligrams (mg), aspirin 81mg, magnesium oxide 400 tablet, Revlimid (used to treat several types of cancer) 5mg, sertraline (depression) 50 mg, potassium chloride 10MEQ, vitamin D3 50 mcg, and Tylenol 500mg.</p> <p>An interview was held on 8/19/25 at 2:00 pm with the Director of Nursing. She stated her expectation would</p>	F0554					

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F0554 SS = D	Continued from page 5 be that medications were never left at the bedside. She went on to say the medication aide should have stayed in the room until all medications were consumed. If the resident did not consume the medications, they should have been discarded.  An interview with the Administrator was conducted on 8/21/25 at 11:00 AM, she revealed she would expect the person passing medications to stay in the resident's room and watch the resident consume all medications.		F0554				
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir  CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).  (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.  (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.  (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.  (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.  (v) The facility is not relieved of its obligation to		F0578				

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F0578 SS = D	<p>Continued from page 6 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and resident, staff and Responsible Party (RP) interviews, the facility failed to ensure a copy of the Medical Power of Attorney advanced directive document was obtained and in the resident's medical record. This was for 1 of 3 residents reviewed for advanced directives (Resident #99).</p> <p>Findings included:</p> <p>Resident #99 was admitted to the facility on 2/14/24 with a diagnosis of dementia.</p> <p>A physician's progress note for Resident #99 dated 8/1/24 revealed in part her family member was listed as her medical power of attorney.</p> <p>Resident #99's care conference record dated 8/2/24 listed her family member as her medical power of attorney.</p> <p>Resident #99's quarterly Minimum Data Set (MDS) assessment dated 7/24/25 revealed she was cognitively intact.</p> <p>Resident #99's facility face sheet listed her family member as her medical power of attorney and RP.</p> <p>There was no evidence in Resident #99's facility medical record of a copy of her medical power of attorney document.</p> <p>On 8/19/25 at 2:47 PM a telephone interview with Resident #99's RP indicated Resident #99 had executed an advanced directive medical power of attorney (POA) document. He stated he served as Resident #99's RP and medical POA. He reported although he could not say when or to whom he had given it, he had brought a copy of the document to the facility to ensure they had record of it. He reported that if there was an issue, he would be glad to provide another copy.</p> <p>On 8/21/25 at 4:20 PM an interview with Resident #99 indicated her family member was her medical power of attorney. She reported the facility should have a copy of the medical power of attorney document.</p>	F0578					

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F0578 SS = D	<p>Continued from page 7</p> <p>On 8/19/25 at 3:17 PM an interview with the Medical Records Director indicated he had been responsible for medical records at the facility since December of 2023. He reported that normally, an advanced directive document such as a medical power of attorney would first go to the Social Worker (SW) or Admissions Director who would then provide the document for him to upload in the resident's medical record. He stated he did not have a medical power of attorney document for Resident #99, and there was not one in her medical record.</p> <p>On 8/19/25 at 3:27 PM an interview with SW #1 indicated she would not be the person to obtain or receive a copy of a resident's medical power of attorney document. She stated this would normally go to the Admissions Director or the Medical Records Director.</p> <p>On 8/19/25 at 3:30 PM an interview with SW #2 indicated he would not be the person to obtain or receive a copy of a resident's medical power of attorney document.</p> <p>On 8/21/25 at 4:13 PM an interview with the Admissions Director indicated if a resident or family member brought him a copy of a medical power of attorney or other advanced directive document, he would provide this to the Medical Records Director to upload into the resident's record. He stated he did not recall ever receiving a copy of Resident #99's medical power of attorney document. He reported he did not see a copy of the document in Resident #99's record.</p> <p>On 8/22/25 at 11:26 AM an interview with the Director of Nursing indicated she was not really sure what the facility's process was for ensuring a copy of any advanced directive including a medical power of attorney a resident had executed was present in the resident's medical record. She reported if she needed to know whether or not a resident had a medical power of attorney and who that was, she would be looking in the medical record to see the document itself.</p> <p>On 8/22/25 at 11:38 AM an interview with the Administrator indicated if a resident had executed an advanced directive such as a medical power of attorney, a copy of the document should be obtained by the facility and scanned into the resident's medical record. She reported the facility did not currently have a plan of correction in place for this issue.</p>	F0578					
F0602 SS = E	<p>Free from Misappropriation/Exploitation</p> <p>CFR(s): 483.12</p>	F0602	"Past Noncompliance - no plan of correction required"				



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F0602 SS = E	<p>Continued from page 8 §483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and resident, staff, Medical Director, and Pharmacist interviews, the facility failed to protect the resident's right to be free from the misappropriation of their narcotic medications (oxycodone and hydrocodone) prescribed to treat pain for 4 of 8 residents reviewed for misappropriation of property (Residents #38, #24, #50, and #107).</p> <p>Findings included:</p> <p>1a. Resident #38 was admitted to the facility on 1/10/2020 with a diagnosis of chronic pain.</p> <p>A physician's order for Resident #38 dated 10/17/24 revealed oxycodone 10 milligrams (mg) take 1 tablet orally every 8 hours for chronic pain.</p> <p>A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 90 tablets of Oxycodone 10 mg were delivered to the facility on 11/18/24 for Resident #38's prescription number. The packing slip was signed by Nurse #2 and Nurse #3 acknowledging this medication was received.</p> <p>Nurse #2's Interviewee Statement dated 12/23/24 indicated Nurse #2 verified she received 3 cards of 30 Oxycodone 10 mg tablets for Resident #38 on 11/18/24 from the pharmacy.</p> <p>Multiple attempts for a telephone interview with Nurse #2 were unsuccessful.</p> <p>On 8/20/25 at 10:58 AM an interview with Nurse #3 indicated her signature on the Packing Slip from the Pharmacy dated 11/18/24 verified that 90 tablets of Oxycodone 10 mg for Resident #38 were received. She stated there would have been 3 cards of 30 tablets</p>		F0602				

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F0602 SS = E	<p>Continued from page 9 each.</p> <p>Resident #38's Medication Administration Record for November 2024 revealed documentation indicating Oxycodone 10 mg was administered to Resident #38 every 8 hours as ordered by the physician from 11/1/24 through 11/30/24.</p> <p>Resident #38's Medication Administration Record for December 2024 revealed documentation indicating Oxycodone 10 mg was administered to Resident #38 every 8 hours as ordered by the physician from 12/1/24 through 12/08/24.</p> <p>The Controlled Substance Count Record labeled 1 of 3 accounting for 30 tablets of Resident #38's Oxycodone 10 mg was missing.</p> <p>The Controlled Substance Count Records labeled 2 of 3 and 3 of 3 for Resident #38's Oxycodone 10 mg revealed the record labeled 3 of 3 was utilized prior to the record labeled 2 of 3.</p> <p>The Controlled Substance Count Record labeled 3 of 3 for Resident #38's Oxycodone 10 mg revealed documentation indicating the first dose of 30 tablets accounted for on the sheet was administered on 11/19/24 at 1:54 PM and the last dose completing the card was administered on 11/29/24 at 1:30 PM.</p> <p>The Controlled Substance Count Record labeled 2 of 3 for Resident #38's Oxycodone 10 mg revealed documentation indicating the first dose of 30 tablets accounted for on the sheet was administered on 11/29/24 at 9:00 PM and the last dose completing the card was administered on 12/07/24 at 10:00 PM.</p> <p>Resident #38's quarterly Minimum Data Set (MDS) assessment dated 8/13/25 revealed he was cognitively intact.</p> <p>On 8/20/25 at 12:09 PM an interview with Resident #38 indicated he had no concerns with receiving his narcotic pain medication.</p>	F0602					

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F0602 SS = E	<p>Continued from page 10</p> <p>On 8/20/25 at 12:18 PM an interview with Corporate Nurse Consultant #1 indicated on 12/8/24, she became aware that Resident #38 required an early refill of his Oxycodone 10 mg medication. She stated an investigation determined Controlled Substance Count Record labeled 1 of 3 for Resident #38's Oxycodone 10 mg and the corresponding 30 doses of Oxycodone 10 mg medication could not be accounted for. Corporate Nurse Consultant #1 confirmed the medication had not been returned to the pharmacy. She reported the unaccounted for medication was replaced by the pharmacy at the facility's expense. She indicated Resident #38 did not miss any doses of the medication.</p> <p>b. Resident #24 was admitted to the facility on 1/29/2020 with a diagnosis of chronic pain.</p> <p>A physician's order for Resident #24 dated 4/29/24 revealed Oxycodone 5 milligrams (mg) take 1 tablet by mouth every 12 hours for pain.</p> <p>A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 60 tablets of Oxycodone 5 mg were delivered to the facility on 10/14/24. The packing slip was signed by Nurse #5 acknowledging this medication was received.</p> <p>Nurse #5's undated Interviewee Statement indicated she confirmed that on 10/14/24 she signed the packing slip for receiving Resident #24's medication. She could not recall any specifics.</p> <p>Attempts to interview Nurse #5 during the investigation were unsuccessful.</p> <p>Resident #24's October 2024 and November 2024 Medication Administration Records revealed documentation Oxycodone 5 mg was administered to Resident #24 every 12 hours as ordered by the physician.</p> <p>The Controlled Substance Count Record labeled 1 of 2 accounting for 30 tablets of Resident #24's Oxycodone 5 mg was missing.</p> <p>The Controlled Substance Count Record labeled 2 of 2</p>	F0602					

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345215</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>08/22/2025</b>	
NAME OF PROVIDER OR SUPPLIER  <b>River Trace Nursing and Rehabilitation Center</b>				STREET ADDRESS, CITY, STATE, ZIP CODE  <b>250 Lovers Lane , Washington, North Carolina, 27889</b>			
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F0602 SS = E	<p>Continued from page 11 accounting for 30 tablets of Resident #24's Oxycodone 5 mg revealed documentation indicting the first of 30 tablets accounted for on the sheet was administered on 10/23/24 at 8:00 PM and the last dose completing the card was administered on 11/4/24 at 8:00 PM.</p> <p>Resident #24's quarterly Minimum Data Set (MDS) assessment dated 8/8/25 revealed she was cognitively intact.</p> <p>On 8/20/25 at 4:27 PM an interview with Resident #24 indicated she had no concerns with receiving her narcotic pain medication.</p> <p>On 8/20/25 at 4:00 PM an interview with Corporate Nurse Consultant #1 indicated as a result of an audit into the facility's narcotic process that began on 12/8/24 it was discovered that the facility received 60 tablets of Oxycodone 5 mg for Resident #24 on 10/14/24 on 2 cards of 30 tablets each. She reported a reconciliation of this medication completed by the facility during the investigation revealed 18 doses could be accounted for beginning on 10/14/24 with the evening dose and ending on 10/23/24 with the morning dose but 12 doses of the medication from card 1 of 2 could not be accounted for. She stated both this medication card and the Controlled Substance Count Record were missing. Corporate Nurse Consultant #1 confirmed the medication had not been returned to the pharmacy. She reported the unaccounted-for medication was replaced by the pharmacy at the facility's expense. She indicated Resident #24 did not miss any doses of the medication.</p> <p>c. Resident #50 was admitted to the facility on 10/14/2020 with a diagnosis of dementia.</p> <p>A physician's order for Resident #50 dated 7/1/24 revealed hydrocodone 5 milligrams (mg)-acetaminophen 325 mg take 1 tablet orally every 12 hours as needed for pain.</p> <p>A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 30 tablets of hydrocodone 5 mg-acetaminophen 325 mg were delivered to the facility on 7/1/24. The packing slip was signed by Nurse #6 acknowledging this medication was received.</p>	F0602					

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F0602 SS = E	<p>Continued from page 12</p> <p>There was no Controlled Substance Count Record for Resident #50's hydrocodone 5 milligrams (mg)-acetaminophen 325 mg delivered to the facility on 7/1/24 available for review.</p> <p>Resident #50's July 2024 Medication Administration Record revealed documentation accounting for 3 doses of hydrocodone 5milligrams (mg)-acetaminophen 325 mg administered to Resident #50. The dates of administration were 7/2/24, 7/16/24, and 7/23/24.</p> <p>Resident #50's August 2024 Medication Administration Record revealed documentation accounting for 3 doses of hydrocodone 5milligrams (mg)-acetaminophen 325 mg administered to Resident #50. The dates of administration were 8/16/24, 8/23/24, and 8/27/24.</p> <p>Resident #50's September 2024 Medication Administration Record revealed documentation accounting for 1 dose of hydrocodone 5milligrams (mg)-acetaminophen 325 mg administered to Resident #50. The date of administration was 9/21/24.</p> <p>Resident #50's October 2024 Medication Administration Record revealed documentation accounting for 2 doses of hydrocodone 5milligrams (mg)-acetaminophen 325 mg administered to Resident #50. The dates of administration were 10/3/24 and 10/24/24.</p> <p>Resident #50's November 2024 Medication Administration Record revealed documentation accounting for 1 dose of hydrocodone 5milligrams (mg)-acetaminophen 325 mg administered to Resident #50. The date of administration was 11/10/24.</p> <p>A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 30 tablets of hydrocodone 5milligrams (mg)-acetaminophen 325 mg were delivered to the facility on 11/11/24 for Resident #50. The packing slip was signed by Nurse #2 and Nurse #7 acknowledging the medication was received.</p> <p>Attempts to interview Nurse #2 and Nurse #7 were unsuccessful.</p> <p>Resident #50's December 2024 Medication Administration</p>	F0602					

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F0602 SS = E	<p>Continued from page 13 Record revealed no documentation accounting for any doses of hydrocodone 5milligrams (mg)-acetaminophen 325 mg administered to Resident #50.</p> <p>There was no Controlled Substance Count Record for Resident #50's hydrocodone 5milligrams (mg)-acetaminophen 325 mg delivered to the facility on 11/11/24 available to review.</p> <p>Resident #50's quarterly Minimum Data Set (MDS) assessment dated 7/28/25 revealed she was severely cognitively impaired.</p> <p>On 8/21/25 at 3:44 PM an interview with Resident #50 indicated she sometimes took medication for back pain. She stated she got her pain medication when she needed it.</p> <p>On 8/21/24 at 3:46 PM an interview with Nurse #10 indicated she was familiar with Resident #50 and cared for her regularly from July 2024 through the present. She reported she had not ever had any concerns with not having Resident #50's narcotic pain medication available to give to Resident #50 if she needed it.</p> <p>On 08/22/2025 at 8:44 AM the facility's Corporate Nurse Consultant #1 stated as a result an audit into the facility's narcotic process that began on 12/8/24 it was discovered that there were missing declining count sheets, missing medications and no shift change sheets for the adding or subtracting the medication cards for Resident #50. Corporate Nurse Consultant #1 reported Resident #50 had a total of 50 tablets of hydrocodone 5 mg acetaminophen 325 mg unaccounted for. She confirmed this medication had not been returned to the pharmacy. She stated the unaccounted for medication was replaced by the pharmacy at the facility's expense. She indicated Resident #50 did not miss any doses of the medication.</p> <p>d. Resident #107 was admitted to the facility on 10/14/24 with a diagnosis of chronic pain.</p> <p>A physician's order for Resident #107 dated 10/24/24 revealed to give 1 tablet of Oxycodone 15 milligrams (mg) by mouth every 8 hours for chronic pain.</p>	F0602					

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F0602 SS = E	<p>Continued from page 14</p> <p>A review of a Packing Slip proof of delivery from the facility's Pharmacy revealed 90 tablets of Oxycodone 15 mg were delivered to the facility on 12/3/24 for Resident #107. The packing slip was signed by Nurse #2 and Nurse #11 acknowledging the medication was received.</p> <p>On 8/21/25 at 9:39 AM a telephone interview with Nurse #11 indicated when narcotic medication was delivered from the pharmacy, 2 nurses would sign the packing slip verifying that the medication was received, and then 2 nurses would sign and verify when the medication was added to the medication cart. She stated she really didn't recall specifically signing for Resident #107's medication on 12/3/24.</p> <p>Attempts to interview Nurse #2 were unsuccessful.</p> <p>Resident #107's December 2024 Medication Administration Record revealed documentation indication that Oxycodone 15 mg was administered to Resident #107 every 8 hours daily from 12/1/24 through 12/31/24.</p> <p>There was no Controlled Substance Count Record labeled 1 of 3 for Resident #107's Oxycodone 15 mg to review.</p> <p>The Controlled Substance Count Record labeled 2 of 3 for Resident #107's Oxycodone 15 mg revealed documentation indicating the first dose of 30 tablets accounted for on the sheet was administered on 12/8/24 at 10:00 PM and the last dose completing the card was administered on 12/18/24 at 2:00 PM.</p> <p>The Controlled Substance Count Record 3 of 3 for Resident #107's Oxycodone 15 mg revealed no doses had been administered to Resident #107 of the 30 doses it recorded.</p> <p>Resident #107's quarterly Minimum Data Set (MDS) assessment dated 7/18/25 revealed he was cognitively intact.</p> <p>On 8/21/25 at 10:23 AM an interview with Resident #107 indicated he got his pain medication when he asked for it.</p>	F0602					

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F0602 SS = E	<p>Continued from page 15</p> <p>On 8/22/25 at 8:44 AM an interview with the facility's Corporate Nurse Consultant #1 indicated on 12/8/24 the facility began an investigation into their narcotic medication reconciliation and accounting process when it became known that Resident #38 required a refill of his narcotic medication before it would have been due. She reported they audited all residents in the facility who received narcotic medication. She indicated she started comparing packing slips with declining count sheets, shift change count sheets and medications returned to the pharmacy for all residents in the facility that were receiving narcotic medication. She indicated she went back 6 months and found there were additional residents with narcotic medications that couldn't be accounted for. Corporate Nurse Consultant #1 stated there were missing medications, missing count sheets and missing packing slips. She reported Nurse #8 and Nurse #9 were the two staff whose names came up the most, and there were suspicions that they were involved in narcotic medication misappropriation. Corporate Nurse Consultant #1 went on to say the information was reported to the Board of Nursing. She stated it was discovered during this audit that Resident #107 had 30 tablets of Oxycodone 15 mg that could not be accounted for. She confirmed this medication had not been returned to the pharmacy. She stated the unaccounted for medication was replaced by the pharmacy at the facility's expense. She indicated Resident #107 had not missed any doses of the medication.</p> <p>On 8/21/25 at 4:44 PM an email communication with Pharmacist #1 indicated he was the Pharmacist in Charge for the facility's pharmacy. He had been informed by Corporate Nurse Consultant #1 that the missing medications for Resident #38, Resident #24, Resident #50, and Resident #107 were believed to have been misappropriated. He indicated the medications had been paid for by the facility. In a follow up email communication with Pharmacist #1 at 4:57 PM he indicated he was not able to provide specific numbers of doses that were unaccounted for. He further indicated he was not at liberty to provide contact numbers for any other pharmacists involved in the incident.</p> <p>On 8/22/25 at 8:09 AM a telephone interview with Administrator #2 indicated she had been the facility's previous Administrator and participated in the investigation of unaccounted for narcotic medication. She reported Nurse Consultant #1 had also participated.</p>	F0602					



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F0602 SS = E	<p>Continued from page 16</p> <p>She stated it was discovered that there were missing medications, missing Controlled Substance Count Records, and missing shift change controlled substance count checks. She reported this started in December 2024 and the facility went back 6 months auditing and reconciling narcotic medication starting with the delivery receipt and the count records, cards and comparing to the Medication Administration Records. She stated she filed 2 Drug Enforcement Agency reports for the missing medication. Administrator #2 indicated they did a 100 percent audit of pain for all residents, no residents had reports or signs of unrelieved pain, and no residents missed any doses of medication. She stated that through the course of the investigation, one nurse kept coming up, so they began to suspect her of misappropriation and reported her to the board of nursing. She reported there was a process change implemented with the facility's narcotic reconciliation process, although she could not recall the specifics. She stated the management nurses monitored the narcotic count for all shifts 7 days of the week for some time; they did 100% education of nurses and med aides and completed follow up audits. She reported she did not recall any concerns with the follow up audits or any other missing narcotics. She stated the Medical Director was involved in the incident and the incident was taken through the facility's Quality Assurance and Performance Improvement (QAPI) process.</p> <p>On 08/22/2025 9:59 am a telephone interview with the facility's Medical Director indicated he had been made aware of the situation with unaccounted for narcotic medication by the facility. He reported that he was not aware of any residents who missed doses of medication or who suffered unrelieved pain as a result. He stated the facility had a process in place whereby if a resident was ordered a narcotic and the facility did not have a dose available the nurse would call him, he would ask what was available in the emergency kit, and order something until the facility could obtain a new supply of the original medication. He reported he participated in the facility's QAPI program meetings.</p> <p>On 8/22/25 at 11:35 AM the facility provided the following corrective action plan:</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p>	F0602					

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F0602 SS = E	<p>Continued from page 17</p> <p>On 12/8/24, the facility was notified by the pharmacist that oxycodone refill request could not be completed due to an early refill request. The assigned nurse pulled the medication from the emergency kit to administer to Resident #38 and the notified the Director of Nursing. The Director of Nursing initiated an investigation into the need to request an early medication refill request. During the investigation, it was identified that one declining count sheet for Oxycodone 10 mg was missing from the medication cart and had not been returned to the pharmacy. The resident did not miss any doses as medication were pulled from the backup emergency kit until the prescription could be refilled.</p> <p>During the investigation of the narcotic process, the facility identified additional residents with narcotic medications that could not be accounted for including Resident #107's 30 tablets of oxycodone 15mg, Resident #50's 50 tablets of Norco 5/325mg, and Resident #24's 12 tablets of oxycodone 5mg.</p> <p>The facility worked with the pharmacy and replaced the medications not able to be located at the facility's expense for the identified residents (Resident #38, Resident #107, Resident #50, and Resident #24).</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 12/9/24, the Director of Nursing (DON) initiated an audit of the packing slips, narcotic shift change sheets, narcotic declining count sheets and return of drug forms from 10/9/2024-12/9/24. This audit is to ensure the facility followed the chain of custody and that medications were available to be administered or were returned to the pharmacy per facility protocol. The Assistant Director of Nursing (ADON) initiated an investigation into any identified areas of concern. This audit was completed by 12/18/2024</p> <p>On 12/9/2024 the DON and Assistant Director of Nursing initiated an audit of all resident's Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart to ensure there were no discrepancies in the count of the medications. During the audit, the unit managers inspected the narcotic blister packs to ensure no</p>	F0602					

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F0602 SS = E	<p>Continued from page 18 evidence of tampering noted. The Director of Nursing addressed all concerns identified during the audit to include returning medications to the pharmacy for any concerns identified and education of staff. This audit was completed by 12/18/2024.</p> <p>On 12/9/2024 ADON initiated an audit of all residents who are unable to report signs/symptoms of pain. The audit was completed by 12/18/2024. There were no concerns identified.</p> <p>On 12/10/24, the Assistant Director of Nursing (ADON) initiated interviews with all alert and oriented residents to include (1) are you currently having pain; (2) if yes, score your pain on a scale of one to 10 with one being mild pain 10 being the worst pain; and (3) do you want anything for pain now? The questionnaires were completed by 12/18/2024. There were no identified concerns.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 12/7/2024, the Administrator initiated a complaint with the North Carolina Board of Nursing against Nurse #8 and Nurse #9 regarding potential misappropriation medications.</p> <p>On 12/10/2024, the payroll manager initiated an audit of all nurse's and medication aides' license verification and Health Care Personnel Investigations (HCPI) checks. This audit was completed by 12/18/24. There were no concerns identified.</p> <p>On 12/18/24, the Regional Nurse Consultant and Regional Assistant Vice President of Health Services removed the Health Care Facility (HCF)-254 form dated 2017 and initiated the HCF-257 form revised 7/2024 which included instructions for completing the HCF-257 form and codes indicating the reason medication was added or removed from the medication cart: Shift Change controlled substance count check form for all medication carts to include the E-kit.</p> <p>On 12/16/24, the Administrator initiated the use of a drop safe box for collection of declining count sheets,</p>	F0602					

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F0602 SS = E	<p>Continued from page 19 completed narcotic medication cards and return of drug slips.</p> <p>On 12/10/2024 the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding (1) Controlled Substance Diversion to include: the definition of diversion and misappropriation, signs of drug diversion, reporting discrepancies and change of custody when handling narcotics, (2) Narcotic Management Process to include (a) process for receiving medications from pharmacy using a 2 nurse verification and adding new medications to shift count sheet (b) shift to shift count process to include documentation of each item removed/added, not writing over previous documentation and a 2 nurse verification of both declining narcotic count sheet and supply on hand at the beginning/end of each shift, (c) procedure for returning controlled substances with emphasis on placing two cards back to back, sealed in appropriate bag for transport, securing medication on a locked cart and counting medication until picked up by designated pharmacy staff and (d) immediately reporting discrepancies to the Director of Nursing. The in-service also included that the nurse should not permit other staff to remove control substances without following the chain of custody with documentation of chain of custody on the declining count sheet and shift change sheet to include verification by two nurses.</p> <p>In-services were completed on 12/18/2024. After 12/18/2024 all nurses or medication aides that have not worked and received the in-service were in-serviced prior to their next scheduled shift. All newly hired nurses and medication aides were in-serviced during orientation regarding Controlled Substance Diversion, Procedure for Returning Controlled Substances and Managing Discontinued Controlled Substances and Controlled Substances of Discharged Resident.</p> <p>On 12/18/24, the facility proactively expanded the education to include a return demonstration of shift-to-shift control substance count, return of unused medications, and receiving new control substance medications beginning 12/18/24 to validate staff knowledge and understanding of the education. After 12/18/24, any nurse or medication aide who had not successfully completed the return demonstration was re-educated by the staff facilitator. Any nurse or medication aide who could not successfully complete the return demonstration after two attempts were not allowed to work until additional training was</p>	F0602					

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F0602 SS = E	<p>Continued from page 20 completed.</p> <p>On 12/18/24, an additional onsite education by the pharmacy consultant was completed regarding the Narcotic Management process. The session covered key areas such as the proper use of the "Return of Drugs" form, safe storage procedures for discontinued medications, the return process involving pharmacy and courier services, and best practices for handling-controlled substances. This education provided additional support to the facility regarding Narcotic Management.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Assistant Director of Nursing, Minimum Data Set Nurse and Staff Facilitator will complete 10 shift change narcotic count observations weekly x 8 weeks then monthly x 1 month to ensure outgoing and incoming nurses perform a correct and accurate count of narcotics to include review of declining count sheet to supply on hand, observation of blister packs for tampering or lose packaging, recording accurate count of narcotic cards/declining count sheets and immediately reporting any discrepancies to the Director of Nursing and/or Administrator. The Assistant Director of Nursing, Minimum Data Set Nurse and Staff Facilitator addressed all concerns identified during the observations to include re-training of staff. The Director of Nursing and/or Assistant Director of Nursing will review the Controlled Substance Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern are addressed.</p> <p>The ADON, Minimum Data Set Nurse (MDS) and Staff Facilitator reviewed packing slips for all newly received controlled substance medications, Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the control substance medications are being administered per physician order or have been returned to pharmacy as required per policy, the nurse or medication aide are completing shift to shift counts accurately and there are no signs of drug diversion weekly x 8 weeks then monthly x 1 month utilizing a Controlled Substance Audit tool. All areas of concern were addressed during the audit to include but not limited to initiating an investigation when indicated and/or re-education of staff. The Administrator reviewed the audits weekly x 8</p>	F0602					

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F0602 SS = E	<p>Continued from page 21 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.</p> <p>The Unit Managers/DON will complete 10 quizzes with nurses and medication aides weekly x 8 weeks then monthly x 1 month. The quiz is to validate staff knowledge and understanding of chain of custody and monitoring of control substances per facility protocol and to identify any concerns related to control substance. The DON addressed all concerns identified during the audit to include but not limited to re-training of staff when indicated.</p> <p>The Administrator or DON presented the findings of the audit tools and quizzes to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months and reviewed to determine trends and/or issues that needed further interventions and the need for additional monitoring.</p> <p>Alleged date of compliance: 12/19/24</p> <p>The facility's plan of correction was validated on 8/22/25 through interviews with nurses and medication aides, a review of the facility's initial audits, in-service education records, a review of the facility's audit tools, a review of the facility's revised HCF-257 form, a review of the facility's record of replacement of medications at the facility's expense, an observation of medication administration to include narcotic administration and reconciliation, an observation of the lock box and the assistant DON's process for monthly review and accounting for narcotics, and the facility's QAPI.</p> <p>The facility's date of completion of 12/19/24 for the corrective action plan was validated.</p>	F0602					
F0656 SS = D	<p>Develop/Implement Comprehensive Care Plan</p> <p>CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a</p>	F0656					

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F0656 SS = D	<p>Continued from page 22 resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review and staff interviews, the facility failed to develop an individualized, person-centered comprehensive care plan to include the use of anticoagulant medication (Resident #54) and diabetes mellitus type II (Resident #97) for 2 of 5 residents reviewed for comprehensive care plans (Resident #54 and Resident #97).</p>	F0656					

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F0656 SS = D	<p>Continued from page 23</p> <p>The findings included:</p> <p>1. Resident #54 was admitted to the facility on 8/1/25 with diagnoses that included atrial fibrillation and coronary artery disease.</p> <p>Resident #54's 5-day Minimum Data Set (MDS) assessment dated 8/7/25 revealed she was severely cognitively impaired and was prescribed an anticoagulant (blood thinning) medication.</p> <p>The comprehensive care plan initiated on 8/4/25 did not reveal a care plan indicating Resident #54 took anticoagulant medication.</p> <p>An interview was conducted with the MDS Nurse on 8/20/25 at 11:43 AM. She indicated the admitting nurse was responsible for adding high risk medications such as anticoagulants to the care plan upon admission.</p> <p>In an interview with the admitting Nurse (Nurse #1) on 8/20/25 at 12:12 PM she stated she did not add medications to care plans when completing an admission. Nurse #1 indicated she was not aware adding medications to the care plan was part of the admission paperwork process.</p> <p>In an interview with the Assistant Director of Nursing (ADON) on 8/20/25 at 12:51 PM, she indicated that staff nurses were supposed to add high risk medication with interventions to the care plan upon admission. She was unaware Resident #54 did not have a care plan for anticoagulant medication.</p> <p>In an interview with the Director of Nursing (DON) on 8/20/25 at 12:54 PM she stated she would expect all residents on anticoagulant medication to have a care plan upon admission given that it was a high-risk drug class. She was unaware Resident #54 did not have a care plan for the medication.</p> <p>An interview was conducted with the Administrator on 8/20/25 at 1:08 PM. She indicated that Resident #54 should have had a care plan for anticoagulant medication upon admission.</p>	F0656					



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F0656 SS = D	<p>Continued from page 24</p> <p>2. Resident #97 was admitted to the facility on 4/25/25 with diagnoses that included diabetes mellitus type II.</p> <p>Resident #97's quarterly MDS assessment dated 7/28/25 indicated he was severely cognitively impaired and was taking a hypoglycemic medication (used to lower blood sugar levels).</p> <p>Review of Resident #97's physician orders revealed he received sliding scale insulin, blood glucose level checks twice daily, received an oral hypoglycemic medication twice daily and was on a consistent carbohydrate diet used to help control blood glucose levels with diet.</p> <p>Review of Resident #97's comprehensive care plan initiated 4/25/25 revealed there was not a care plan for diabetes mellitus type II.</p> <p>In an interview with the MDS nurse on 8/20/25 at 11:43 AM she stated the admitting Nurse (Nurse #1) would have been responsible for initiating the diabetes mellitus type II care plan upon admission.</p> <p>In an interview with the admitting Nurse (Nurse #1) on 8/20/25 at 12:12 PM she stated she did not add diagnoses to care plans when completing an admission. Nurse #1 indicated she was not aware adding diagnoses to the care plan was part of the admission paperwork process.</p> <p>In an interview with the Assistant Director of Nursing (ADON) on 8/20/25 at 12:51 PM, she indicated that staff nurses were supposed to add high risk diagnoses such as diabetes mellitus type II with interventions to the care plan upon admission. She was unaware Resident #97 did not have a care plan for diabetes mellitus type II.</p> <p>In an interview with the Director of Nursing (DON) on 8/20/25 at 12:54 PM she stated she would expect all residents who have diabetes mellitus type II to have a care plan upon admission as it was a high-risk diagnosis. She was unaware Resident #97 did not have a care plan for diabetes mellitus type II.</p>	F0656					

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F0656 SS = D	Continued from page 25  An interview was conducted with the Administrator on 8/20/25 at 1:08 PM. She indicated that Resident #97 should have had a care plan for diabetes mellitus type II upon admission.	F0656					
F0657 SS = D	Care Plan Timing and Revision  CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans  §483.21(b)(2) A comprehensive care plan must be-  (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to--  (A) The attending physician.  (B) A registered nurse with responsibility for the resident.  (C) A nurse aide with responsibility for the resident.  (D) A member of food and nutrition services staff.  (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.  (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.  (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review and staff interviews the facility failed to revise the comprehensive care plan to accurately reflect the code status for 1 of 3 residents reviewed for advanced directives (Resident #108).  Findings included:	F0657					

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F0657 SS = D	<p>Continued from page 26 Resident #108 was admitted to the facility on 5/6/24 with a diagnosis of dementia.</p> <p>Resident #108's active comprehensive care plan revealed a focus area for advanced directives. The goal was for Resident #108's advanced directives to be honored per the established documentation through the next review. An intervention was Cardio-Pulmonary Resuscitation (CPR is a lifesaving procedure performed when someone's heartbeat or breathing has stopped) Full Code.</p> <p>A physician's order for Resident #108 dated 7/31/25 entered into Resident #108's electronic medical record by the Assistant Director of Nursing (ADON) was Do Not Resuscitate (DNR is the refusal of CPR).</p> <p>On 8/21/25 at 4:03 PM an interview with the ADON indicated she entered the DNR order into Resident #108's electronic medical record on 7/31/25. She stated she would have been responsible for updating Resident #108's comprehensive care plan to accurately reflect Resident #108's code status of DNR at that time. She reported she did not know why she had not.</p> <p>On 8/22/25 at 11:38 AM an interview with the Administrator indicated the ADON should have updated Resident #108's comprehensive care plan when she entered the physician's order changing Resident #108's code status to DNR.</p>	F0657					
F0726 SS = J	<p>Competent Nursing Staff</p> <p>CFR(s): 483.35(a)(3)(4)(d)</p> <p>§483.35 Nursing Services</p> <p>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.</p> <p>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p>	F0726					

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F0726 SS = J	<p>Continued from page 27</p> <p>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>§483.35(d) Proficiency of nurse aides.</p> <p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and staff and Medical Director interviews, the facility failed to ensure staff were trained and competent in following manufacturer's guidelines for cleaning and disinfecting a shared glucometer for 1 of 1 observed (Resident #34). On 8/20/25 Nurse #1 was observed obtaining Resident #34's blood glucose (sugar) level followed by the nurse cleaning the glucometer with an alcohol wipe that was not an Environmental Protection Agency (EPA)-registered disinfectant. Nurse #1 revealed she worked at the facility since March of 2025, had always used an alcohol wipe to clean the glucometer, had not been trained on how to disinfect the glucometer, and was unaware an EPA-registered disinfectant needed to be used. The Infection Preventionist revealed she was unsure what the manufacturer's guidelines were for cleaning and disinfecting a shared glucometer. Resident #34 resided on the locked unit and this shared glucometer was utilized for 2 other residents (Residents #92 and #97) who resided on that unit. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to ensure staff are trained and competent to disinfect a shared glucometer in accordance with the manufacturer's instructions has the high likelihood to expose residents to bloodborne pathogens. There were no residents with a blood-borne pathogen in the facility at the time of the investigation. The deficient practice was identified for 1 of 3 nursing staff members (Nurse #1) reviewed for glucometer disinfection competency.</p> <p>Immediate Jeopardy began on 8/20/25 when Nurse #1</p>	F0726					

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F0726 SS = J	<p>Continued from page 28</p> <p>failed to demonstrate competency to disinfect a shared glucometer per manufacturer's instructions. Immediate jeopardy was removed on 8/22/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education is completed and monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>A continuous observation of Nurse #1 was conducted on 8/20/25 from 12:36 PM through 12:51 PM revealed the following:</p> <p>On 8/20/25 at 12:36 PM, Nurse #1 was standing by the medication cart in the day room of the locked unit with Resident #34 standing next to her. Nurse #1 took the glucometer out of the top left drawer of the cart where it had been stored. Nurse #1 put the glucometer on top of the cart, gathered supplies and obtained Resident #34's blood glucose. The Nurse was observed to clean the glucometer with a small alcohol wipe for less than one minute and place the glucometer back into the top left drawer of the medication cart.</p> <p>In an interview with Nurse #1 during the observation that began on 8/20/25 at 12:36 PM she stated the glucometer was used on all residents in the locked unit that had orders for blood glucose testing. Nurse #1 further stated she had worked in the facility since March of 2025 and had always used an alcohol wipe to clean the glucometer. Nurse #1 indicated she had not been trained on how to disinfect the glucometer with an EPA-registered germicidal wipe.</p> <p>A follow-up interview was conducted with Nurse #1 on 8/20/25 at 1:37 PM. She revealed there was only one resident (Resident #34) who required blood glucose monitoring at lunchtime. Nurse #1 indicated she had completed three blood glucose checks before breakfast on 8/20/25 and used an alcohol wipe to clean the glucometer between each resident (Resident #34, Resident #92 and Resident #97).</p> <p>An interview on 8/20/25 at 12:54 PM with the Infection Preventionist (IP), who was also the Director of</p>	F0726					

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F0726 SS = J	<p>Continued from page 29</p> <p>Nursing (DON) revealed each medication cart in the facility had one glucometer to be used for all residents on that hall that require blood glucose testing. The IP/DON indicated nurses should be cleaning and disinfecting the glucometers per manufacturer's instruction and facility policy. She stated that she had only been at the facility for three weeks and was unsure when the last in-service/training on glucose monitor disinfection was conducted. The IP further stated she was unsure what the facility policy or manufacturer's instructions for glucometer cleaning and disinfecting instructed. She indicated she was aware that improper disinfection of a shared glucometer could lead to blood-borne pathogens being transferred from one resident to another.</p> <p>A follow-up interview was conducted on 8/20/25 at 2:03 PM with the IP/DON. She stated there were no residents with known blood-borne pathogens in the facility.</p> <p>In an interview with the Administrator on 8/20/25 at 1:08 PM she indicated Nurses should be disinfecting glucometers per manufacturer's instructions between each resident and before use if it is stored with other items such as in the medication cart drawer. The Administrator was unsure when the last in-service training was conducted on the cleaning and disinfecting of glucose monitors.</p> <p>A telephone interview was conducted on 8/21/25 at 8:50 AM with the Medical Director who stated all nursing staff should be educated regarding the cleaning and disinfecting of glucose monitoring before their first shift at the facility.</p> <p>The facility was unable to provide documentation that Nurse #1 was educated on cleaning and disinfecting glucose monitors. They were also unable to provide documentation regarding any in-services that trained nursing staff on cleaning and disinfecting glucometers.</p> <p>The Administrator was notified of immediate jeopardy on 8/21/25 at 9:30 AM.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p>		F0726				

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F0726 SS = J	<p>Continued from page 30</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:</p> <p>On 8/20/25, Nurse #1 removed a glucometer from the 500-hall medication cart drawer. Nurse #1 performed the blood glucose check on Resident #34 then wiped the glucometer with an alcohol wipe and placed the glucometer back into the medication cart drawer. Nurse #1 stated she was not aware to use an Environmental Protection Agency (EPA) germicidal approved wipe and was not trained regarding the facility's policy/procedures for glucometer disinfection, or which product was approved to disinfect the glucometer.</p> <p>On 8/20/25, the Facility Consultant completed a medical record audit of all residents, including Resident #34, Resident #92, and Resident #97, who received blood glucose checks. This audit was to identify any diagnosed blood-borne pathogen infections to ensure there were no infections related to improper cleaning and disinfecting of glucometers. No residents were identified with a blood-borne pathogen.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:</p> <p>On 8/21/25, the accounts payable will audit all nurses and Medication Aide employee files to verify education and completion of skills checklist to validate competency for disinfecting shared glucometers according to manufacturer's instructions upon hire. The Director of Nursing will ensure all nurses and Medication Aides without education and/or a completed skills checklist will have it completed prior to the employee starting their next scheduled shift.</p> <p>On 8/21/25, the Nurse Consultant educated the Administrator and Director of Nursing regarding the requirements to ensure all facility and agency nurses, and Medication Aides are educated on the policy and procedures for cleaning and disinfecting a glucometer and complete a skills checklist with observation of a return demonstration to validate competency during orientation.</p> <p>On 8/20/25, the Director of Nursing, Assistant Director of Nursing, Treatment Nurse and Unit Managers</p>	F0726					

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F0726 SS = J	<p>Continued from page 31</p> <p>initiated, in person, education with all nurses to include Nurse #1 and medication aides regarding the importance of following facility and manufacturer's instructions for cleaning and disinfecting a shared glucometer including (1) using a EPA registered germicidal disposable cloth/wipes (2) exposure times (3) dry time (4) the policy/procedure for cleaning and disinfecting glucometers (5) germicidal instructions for cleaning and disinfecting a glucometer are located on the container of the germicidal wipes (6) the risk factors of not properly cleaning shared glucometers (7) approved products for disinfecting a glucometer (8) proper storage of glucometers to prevent cross contamination. The in-service will be completed by 8/20/25. The Director of Nursing will monitor the completion of staff in-services. After 8/20/25, any nurse or medication aide who has not worked or received the in-service will receive the education prior to the next scheduled work shift. All newly hired nurses or medication aides including agency, will be in-serviced by the Director of Nursing, Assistant Director of Nursing or Unit Managers during orientation regarding the importance of following facility and manufacturer's instructions for cleaning and disinfecting a shared glucometer.</p> <p>On 8/20/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers initiated in-person return demonstrations of properly cleaning and disinfecting glucometers with all nurses to include Nurse #1 and all medication aides including agency. The purpose of the return demonstrations is to ensure that staff demonstrate knowledge and understanding of the glucometer cleaning and disinfecting procedures, including adhering to the manufacturer's instructions. Staff will be immediately retrained for any identified areas of concern. The return demonstrations will be completed by 8/20/25. Any nurse or medication aide who does not successfully pass the return demonstration will be immediately re-educated and will be required to repeat the return demonstration until successful demonstration is achieved. The return demonstrations were completed by 8/20/25 for all nurses and medication aides who worked. The Director of Nursing will monitor the completion of the glucometer cleaning return demonstrations. After 8/20/25, staff who have not completed the return demonstrations will complete it prior to their next scheduled work shift.</p> <p>On 8/20/25, the Director of Nursing, Assistant Director of Nursing and Unit Managers initiated in person quizzes with all nurses to include Nurse #1 and medications aides, including agency to validate knowledge and understanding of the importance of</p>		F0726				



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F0726 SS = J	<p>Continued from page 32 following facility and manufacturer's instructions for cleaning and disinfecting a shared glucometer. The quizzes included (1) how often do you need to clean a glucometer (2) what should you use to clean and disinfect a glucometer? (3) why is it important to follow the manufacturer's instructions to clean and disinfect a shared glucometer? (4) how do you know the exposure time for the disinfectant you are utilizing? Any nurse or medication aide that does not successfully pass the quiz will be immediately re-educated and will be required to retake the quiz at the time of administration until a successful passing score is achieved. The quizzes were completed by 8/20/25 for all nurses and medication aides who worked. The Director of Nursing will monitor the completion of staff quizzes. After 8/20/25, any nurse or medication aide who has not completed the quiz will complete it prior to their next scheduled work shift.</p> <p>Alleged immediate jeopardy removal date: 8/22/25.</p> <p>Validation of the immediate jeopardy removal plan was conducted on 8/22/25. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing, Assistant Director of Nursing or Unit Manager. An observation was conducted of glucose disinfection while onsite. The staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers.</p> <p>The immediate jeopardy removal date of 8/22/25 was validated.</p>	F0726					
F0755 SS = E	<p>Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p>	F0755	"Past Noncompliance - no plan of correction required"				

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F0755 SS = E	<p>Continued from page 33</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and resident, staff, Medical Director, and Pharmacist interviews, the facility failed to have effective safeguards and systems in place to prevent drug diversion of discontinued controlled narcotic and antianxiety medications (hydromorphone, oxycodone, morphine and lorazepam). This was for 3 of 8 residents reviewed for misappropriation (Residents #8, #115, and #141).</p> <p>Findings included:</p> <p>1a. Resident #8 was admitted to the facility on 12/8/2011 with a diagnosis of arthritis.</p> <p>A physician's order for Resident #8 dated 11/13/24 revealed hydromorphone (narcotic medication) 2 milligram (mg) tablet take 1 tablet every 4 hours as needed for mild hand amputation pain and 2 tablets as needed every 4 hours for moderate to severe pain.</p> <p>A Packing Slip proof of delivery from the facility's Pharmacy revealed 60 tablets of hydromorphone 2 mg were</p>		F0755				

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F0755 SS = E	<p>Continued from page 34 delivered to the facility on 11/13/24 for Resident #8. The packing slip was signed by Nurse #6 acknowledging this medication was received.</p> <p>Nurse #6's Interviewee Statement dated 12/26/24 revealed she confirmed she received 2 cards of 30 tablets each of Resident #8's hydromorphone 2 mg from the pharmacy on 11/13/24. It further revealed Nurse #6 indicated the medication would have been placed on the medication cart.</p> <p>Attempts to interview Nurse #6 during the investigation were unsuccessful.</p> <p>On 12/6/24 Resident #8's order for hydromorphone from 11/13/24 was discontinued when he was discharged to the hospital.</p> <p>The Occurrence Investigation Report for Resident #8 dated 12/20/24 revealed in part documentation of administration on his November and December 2024 Medication Administration Records accounted for 12 tablets from the supply of 60 hydromorphone tablets delivered on 11/13/24. This would have been the only supply of hydromorphone available to administer to Resident #8.</p> <p>There was no Controlled Substance Count Record for the hydromorphone.</p> <p>Resident #8's annual Minimum Data Set (MDS) assessment dated 7/2/25 revealed he was cognitively intact.</p> <p>On 8/20/25 at 2:47 PM an interview with Resident #8 indicated he had no concerns with receiving his pain medication when he needed it until he was discharged to the hospital.</p> <p>On 8/20/25 at 1:10 PM an interview with Corporate Nurse Consultant #1 indicated as a result of an audit into the facility's narcotic process that began on 12/8/24 it was discovered that a number of Resident #8's hydromorphone 2 mg tablets received by Nurse #6 on 11/13/24 were unaccounted for. She reported after a review of Resident #8's Medication Administration Record (MAR), it was determined 12 tablets from this</p>	F0755					

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F0755 SS = E	<p>Continued from page 35 prescription could be accounted for through documentation on the MAR of administration. She went on to say there were no Controlled Substance Count Records, no shift change sheet to confirm the medication was ever added to a medication cart, and no accounting for the remaining 48 tablets of the 60 tablet prescription. She stated the pharmacy had verified that the remaining medication had not been returned to the pharmacy after it was discontinued on 12/6/24 when Resident #8 was discharged to the hospital. Corporate Nurse Consultant #1 reported the facility's process for controlled narcotic medication at that time was for 1 nurse to sign the packing slip with the courier verifying that the medication was received and only one nurse to sign the declining Controlled Substance Count Records sheet verifying the receipt and only one nurse to sign the shift change sheet when adding medication to a cart. She reported that this process had changed since the incident.</p> <p>b. Resident #115 was admitted to the facility on 7/3/23 with a diagnosis of arthritis.</p> <p>A physician's order for Resident #115 dated 11/5/24 revealed to take 1 tablet of Oxycodone (a narcotic medication) 5 mg every 4 hours as needed for pelvic fracture pain.</p> <p>A Packing Slip proof of delivery from the facility's Pharmacy revealed 30 tablets of Oxycodone 5 mg was delivered to the facility on 11/5/24 for Resident #115. The packing slip was signed by Nurse #2 and Nurse #11 acknowledging this medication was received.</p> <p>Attempts to interview Nurse #2 were unsuccessful.</p> <p>On 8/21/25 at 9:39 AM a telephone interview with Nurse #11 indicated when narcotic medication was delivered from the pharmacy, 2 nurses would sign the packing slip verifying that the medication was received, and then 2 nurses would sign and verify when the medication was added to the medication cart. She stated she really didn't recall specifically signing for Resident #115's medication on 11/5/24.</p> <p>Resident #115's Medication Administration Records (MARs) for November and December 2024 revealed documentation that 1 tablet of Oxycodone 5 mg was</p>		F0755				

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F0755 SS = E	<p>Continued from page 36 administered to her on 11/10/25 and 11/12/24.</p> <p>There was no Controlled Substance Count Record for the oxycodone.</p> <p>On 12/1/24 Resident #115's order for Oxycodone from 11/5/24 was discontinued.</p> <p>Resident #115's annual Minimum Data Set (MDS) assessment dated 5/28/25 revealed she was severely cognitively impaired.</p> <p>On 8/20/2025 at 5:06 PM an interview with Medication Aide (MA) #6 indicated she was familiar with Resident #115 and cared for her in November 2024. She reported she had no concerns with not having Resident #115's narcotic pain medication available to administer to her if she needed it.</p> <p>On 8/20/25 at 1:10 PM an interview with Corporate Nurse Consultant #1 indicated as a result of an audit into the facility's narcotic process that began on 12/8/24 it was discovered Resident #115's 30 tablets of Oxycodone 5mg was received on 11/5/24. She reported after reviewing Resident 115's MAR, it was determined 2 tablets from this prescription were accounted for through documentation on the MAR of administration. She went on to say there was no Controlled Substance Count Record and no accounting for the remaining 28 tablets of the 30 tablet prescription. She stated the pharmacy had verified that the remaining medication was not returned to the pharmacy after it was discontinued on 12/1/24.</p> <p>c. Resident #141 was admitted to the facility on 6/6/2018 with a diagnosis of dementia.</p> <p>Resident #114's physician's orders revealed an order dated as initiated on 9/18/24 for Morphine Sulfate (narcotic medication) oral solution 100 milligrams (mg) per 5 milliliters (ml) take 0.25 ml by mouth every 2 hours as needed for pain. An additional physician's order dated as initiated on 9/18/24 was for lorazepam (anxiety medication) 0.5 mg tablets take 1 tablet by mouth as needed for restlessness.</p> <p>A Packing Slip proof of delivery from the facility's Pharmacy revealed on 9/18/24 30 ml of Morphine Sulfate oral solution 100 mg/5 ml for Resident #141 and 30</p>	F0755					

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F0755 SS = E	<p>Continued from page 37</p> <p>tablets of lorazepam 0.5 mg tablets for Resident #141 were delivered to the facility. The packing slip was signed by Nurse #8 acknowledging the medication was received.</p> <p>Nurse #8 no longer worked at the facility and was unavailable for interview.</p> <p>A review of Resident #141's September 2024 Medication Administration Record (MAR) did not reveal any documentation indicating doses of either prescription were administered to him on 9/18/24 or 9/19/24.</p> <p>There was no Controlled Substance Count Record for the morphine sulfate or the lorazepam.</p> <p>A Nursing Progress note for Resident #141 dated 9/19/24 at 1:41 AM revealed Resident #141 had no pulse, and hospice and the Medical Director were notified.</p> <p>On 08/22/2025 8:44 AM The facility's Corporate Nurse Consultant #1 stated initially on 12/8/24 she was alerted of a potential issue with controlled medications when there was an early refill request for a resident's narcotic medication. She reported she started comparing packing slips with declining count sheets, shift change count sheets and medications returned to the pharmacy for all residents in the facility that were receiving narcotic medication. She indicated she went back 6 months and found there were additional residents with narcotic medications that couldn't be accounted for. Corporate Nurse Consultant #1 stated there were missing medications, missing count sheets and missing packing slips. She reported Nurse #8 and Nurse #9 were the two staff whose names came up the most, and there were suspicions that they were involved in narcotic medication misappropriation. She went on to say the information was reported to the Board of Nursing. She reported there was no documentation indicating many doses from the missing prescriptions were administered and multiple medications were unaccounted for. Corporate Nurse Consultant #1 there was no Controlled Substance Count Record for many prescriptions. She indicated the pharmacy had confirmed the unaccounted for medications had not been returned to them. She stated the unaccounted for medications were reimbursed at the facility's expense.</p> <p>On 8/21/25 at 4:44 PM an email communication with Pharmacist #1 indicated he was the Pharmacist in Charge for the facility's pharmacy. He had been informed by Corporate Nurse Consultant #1 that the missing narcotic medications for Resident #8, Resident #115, and for</p>	F0755					

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F0755 SS = E	<p>Continued from page 38</p> <p>Resident #141 were believed to have been misappropriated. He indicated the medications had been paid for by the facility. In a follow up email communication with Pharmacist #1 at 4:57 PM he indicated he was not able to provide specific numbers of doses that were unaccounted for. He further indicated he was not at liberty to provide contact numbers for any other pharmacists involved in the incident.</p> <p>On 8/22/25 at 8:09 AM a telephone interview with Administrator #2 indicated she had been the facility's previous Administrator and participated in the investigation of unaccounted for narcotic medication. She reported Nurse Consultant #1 had also participated. She stated it was discovered that there were missing medications, missing Controlled Substance Count Records, and missing shift change controlled substance count checks. She reported this started in December 2024 and the facility went back 6 months auditing and reconciling narcotic medication starting with the delivery receipt and the count records, cards and comparing to the Medication Administration Records. She stated she filed 2 Drug Enforcement Agency reports for the missing medication. Administrator #2 indicated they did a 100 percent audit of pain for all residents, no residents had reports or signs of unrelieved pain, and no residents missed any doses of medication. She stated that through the course of the investigation, one nurses kept coming up, so they began to suspect her of misappropriation and reported her to the board of nursing. She reported there was a process change implemented with the facility's narcotic reconciliation process, although she could not recall the specifics. She stated the management nurses monitored the narcotic count for all shifts 7 days of the week for some time; they did 100% education of nurses and med aides and completed follow up audits. She reported she did not recall any concerns with the follow up audits or any other missing narcotics. She stated the medical director was involved in the incident and the incident was taken through the facility's Quality Assurance and Performance Improvement (QAPI) process.</p> <p>On 08/22/2025 9:59 am a telephone interview with the facility's Medical Director indicated he had been made aware of the situation with unaccounted for narcotic medication by the facility. He reported that he is not aware of any residents who missed doses of medication or who suffered unrelieved pain as a result. He stated the facility had a process in place whereby if a resident was ordered a narcotic and the facility did</p>	F0755					

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F0755 SS = E	<p>Continued from page 39 not have a dose available the nurse would call him, he would ask what was available in the emergency kit, and order something until the facility could obtain a new supply of the original medication. He reported he participated in the facilities QAPI program meetings.</p> <p>On 8/22/25 at 11:35 AM the facility provided the following corrective action plan:</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 12/8/24, the facility was notified by the pharmacist that oxycodone refill request could not be completed due to an early refill request. The assigned nurse pulled the medication from the emergency kit to administer to Resident #38 and the notified the Director of Nursing. The Director of Nursing initiated an investigation into the need to request an early medication refill request. During the investigation, it was identified that one declining count sheet for Oxycodone 10 mg was missing from the medication cart and had not been returned to the pharmacy. The resident did not miss any doses as medication were pulled from the backup emergency kit until the prescription could be refilled.</p> <p>During the investigation of the narcotic process, the facility identified additional residents with narcotic medications that could not be accounted for including Resident #8's 48 tablets of hydromorphone 30 tablets, Resident #115's 28 tablets of oxycodone and Resident #141's 30 ml of morphine sulfate and 30 tablets of lorazepam.</p> <p>The facility worked with the pharmacy and reimbursed for the medications not able to be located at the facility's expense for the identified residents (Resident #8, Resident #115, and Resident #141).</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 12/9/24, the Director of Nursing (DON) initiated an audit of the packing slips, narcotic shift change</p>		F0755				



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F0755 SS = E	<p>Continued from page 40 sheets, narcotic declining count sheets and return of drug forms from 10/9/2024-12/9/24. This audit is to ensure the facility followed the chain of custody and that medications were available to be administered or were returned to the pharmacy per facility protocol. The Assistant Director of Nursing (ADON) initiated an investigation into any identified areas of concern. This audit was completed by 12/18/2024</p> <p>On 12/9/2024 the DON and Assistant Director of Nursing initiated an audit of all resident's Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart to ensure there were no discrepancies in the count of the medications. During the audit, the unit managers inspected the narcotic blister packs to ensure no evidence of tampering noted. The Director of Nursing addressed all concerns identified during the audit to include returning medications to the pharmacy for any concerns identified and education of staff. This audit was completed by 12/18/2024.</p> <p>On 12/9/2024 ADON initiated an audit of all residents who are unable to report signs/symptoms of pain. The audit was completed by 12/18/2024. There were no concerns identified.</p> <p>On 12/10/24, the Assistant Director of Nursing (ADON) initiated interviews with all alert and oriented residents to include (1) are you currently having pain; (2) if yes, score your pain on a scale of one to 10 with one being mild pain 10 being the worst pain; and (3) do you want anything for pain now? The questionnaires were completed by 12/18/2024. There were no identified concerns.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 12/7/2024, the Administrator initiated a complaint with the North Carolina Board of Nursing against Nurse #8 and Nurse #9 regarding potential misappropriation medications.</p> <p>On 12/10/2024, the payroll manager initiated an audit of all nurse's and medication aides' license verification and Health Care Personnel Investigations</p>	F0755					

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F0755 SS = E	<p>Continued from page 41 (HCPI) checks. This audit was completed by 12/18/24. There were no concerns identified.</p> <p>On 12/18/24, the Regional Nurse Consultant and Regional Assistant Vice President of Health Services removed the Health Care Facility (HCF)-254 form dated 2017 and initiated the HCF-257 form revised 7/2024 which included instructions for completing the HCF-257 form and codes indicating the reason medication was added or removed from the medication cart: Shift Change controlled substance count check form for all medication carts to include the E-kit.</p> <p>On 12/16/24, the Administrator initiated the use of a drop safe box for collection of declining count sheets, completed narcotic medication cards and return of drug slips.</p> <p>On 12/10/2024 the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding (1) Controlled Substance Diversion to include: the definition of diversion and misappropriation, signs of drug diversion, reporting discrepancies and change of custody when handling narcotics, (2) Narcotic Management Process to include (a) process for receiving medications from pharmacy using a 2 nurse verification and adding new medications to shift count sheet (b) shift to shift count process to include documentation of each item removed/added, not writing over previous documentation and a 2 nurse verification of both declining narcotic count sheet and supply on hand at the beginning/end of each shift, (c) procedure for returning controlled substances with emphasis on placing two cards back to back, sealed in appropriate bag for transport, securing medication on a locked cart and counting medication until picked up by designated pharmacy staff and (d) immediately reporting discrepancies to the Director of Nursing.</p> <p>The in-service also included that the nurse should not permit other staff to remove control substances without following the chain of custody with documentation of chain of custody on the declining count sheet and shift change sheet to include verification by two nurses.</p> <p>In-services were completed on 12/18/2024. After 12/18/2024 all nurses or medication aides that have not worked and received the in-service were in-serviced prior to their next scheduled shift. All newly hired</p>		F0755				

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F0755 SS = E	<p>Continued from page 42 nurses and medication aides were in-serviced during orientation regarding Controlled Substance Diversion, Procedure for Returning Controlled Substances and Managing Discontinued Controlled Substances and Controlled Substances of Discharged Resident.</p> <p>On 12/18/24, the facility proactively expanded the education to include a return demonstration of shift-to-shift control substance count, return of unused medications, and receiving new control substance medications beginning 12/18/24 to validate staff knowledge and understanding of the education. After 12/18/24, any nurse or medication aide who had not successfully completed the return demonstration was re-educated by the staff facilitator. Any nurse or medication aide who could not successfully complete the return demonstration after two attempts were not allowed to work until additional training was completed.</p> <p>On 12/18/24, an additional onsite education by the pharmacy consultant was completed regarding the Narcotic Management process. The session covered key areas such as the proper use of the "Return of Drugs" form, safe storage procedures for discontinued medications, the return process involving pharmacy and courier services, and best practices for handling-controlled substances. This education provided additional support to the facility regarding Narcotic Management.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Assistant Director of Nursing, Minimum Data Set Nurse and Staff Facilitator will complete 10 shift change narcotic count observations weekly x 8 weeks then monthly x 1 month to ensure outgoing and incoming nurses perform a correct and accurate count of narcotics to include review of declining count sheet to supply on hand, observation of blister packs for tampering or lose packaging, recording accurate count of narcotic cards/declining count sheets and immediately reporting any discrepancies to the Director of Nursing and/or Administrator. The Assistant Director of Nursing, Minimum Data Set Nurse and Staff Facilitator addressed all concerns identified during the observations to include re-training of staff. The Director of Nursing and/or Assistant Director of Nursing will review the Controlled Substance Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all</p>	F0755					

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F0755 SS = E	<p>Continued from page 43 areas of concern are addressed.</p> <p>The ADON, Minimum Data Set Nurse (MDS) and Staff Facilitator reviewed packing slips for all newly received controlled substance medications, Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the control substance medications are being administered per physician order or have been returned to pharmacy as required per policy, the nurse or medication aide are completing shift to shift counts accurately and there are no signs of drug diversion weekly x 8 weeks then monthly x 1 month utilizing a Controlled Substance Audit tool. All areas of concern were addressed during the audit to include but not limited to initiating an investigation when indicated and/or re-education of staff. The Administrator reviewed the audits weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.</p> <p>The Unit Managers/DON will complete 10 quizzes with nurses and medication aides weekly x 8 weeks then monthly x 1 month. The quiz is to validate staff knowledge and understanding of chain of custody and monitoring of control substances per facility protocol and to identify any concerns related to control substance. The DON addressed all concerns identified during the audit to include but not limited to re-training of staff when indicated.</p> <p>The Administrator or DON presented the findings of the audit tools and quizzes to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months and reviewed to determine trends and/or issues that needed further interventions and the need for additional monitoring.</p> <p>Alleged date of compliance: 12/19/24</p> <p>The facility's plan of correction was validated on 8/22/25 through interviews with nurses and medication aides, a review of the facility's initial audits, in-service education records, a review of the facility's audit tools, a review of the facility's revised HCF-257 form, a review of the facility's record of replacement of medications at the facility's expense, an observation of medication administration to include narcotic administration and reconciliation, an observation of the lock box and the assistant DON's</p>	F0755					

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F0755 SS = E	Continued from page 44 process for monthly review and accounting for narcotics, and the facility's QAPI.	F0755					
F0773 SS = D	<p>The facility's date of completion of 12/19/24 for the corrective action plan was validated.</p> <p>Lab Svcs Physician Order/Notify of Results</p> <p>CFR(s): 483.50(a)(2)(i)(ii)</p> <p>§483.50(a)(2) The facility must-</p> <p>(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.</p> <p>(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff and Medical Director interviews, the facility failed to notify the physician or Nurse Practitioner (NP) of abnormal laboratory test results. This deficient practice affected 1 of 6 sampled residents (Resident #130).</p> <p>Resident #130 was admitted to the facility on 10/8/2024 with diagnoses that included obstructive sleep apnea, chronic kidney disease, chronic atrial fibrillation (a condition where the heart beats irregularly and often too fast), and congestive heart failure.</p> <p>Resident #130 had a telephone order called in from the NP from the Cardiology office on 10/11/24 for a BMP (basic metabolic panel, which was a common blood test that measures glucose, calcium, sodium, potassium, chloride, carbon dioxide, blood urea nitrogen and creatinine), draw to be done at the facility. The order was signed off by a nurse on 10/14/2024.</p> <p>Several unsuccessful attempts were made to reach the NP that ordered the lab.</p> <p>Review of the lab results report showed the blood specimen was collected on 10/16/2024, reported to the facility on 10/18/24 and reviewed by the Medical Director on 10/21/2024. The lab results showed out of</p>	F0773					

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F0773 SS = D	<p>Continued from page 45 range for glucose which was 113 with a reference range of 70-99, creatinine which was 1.53 with a reference range of .57-1.00, carbon dioxide which was 19 with a reference range of 20-29, red blood count 3.60 with a reference range of 3.77-5.28, hemoglobin which was 11.0 with a reference range of 11.1-15.9, hematocrit which was 33.6 with a reference range of 34.0-46.6, and iron which was 23 with a reference range of 27-139.</p> <p>An interview was held with the patient access representative at the cardiology office on 8/20/2025 at 12:30 PM. She stated the office never received the results of Resident #130's BMP. She went on to say the NP ordered additional blood work on 10/30/2024 to be completed at an offsite provider and the results were reported to the NP the same day.</p> <p>An interview with the Assistant Director of Nursing was held on 8/20/2025 at 11:00 AM at which time she revealed the facility completes the blood drawings and the results should have been reported to the provider that ordered the blood test.</p> <p>A telephone interview with the facility Medical Director was held on 8/20/2025 at 2:00 PM, and he referred this surveyor back to the Assistant Director of Nursing to see who should have reported the lab results to the ordering provider. He went on to say he did not feel the lack of reporting adversely affected this resident.</p> <p>And interview was conducted with the Director of Nursing on 8/20/2025 at 3:15 PM, she revealed she was not sure of the policy as she was new to the facility. She went on to say typically lab results would be a provider-to-provider conversation.</p> <p>A follow up interview with the Assistant Director of Nursing was conducted on 8/20/2025 at 3:30 PM, she stated the nurse assigned to the hall where the resident lived should have called in the results to the provider that ordered the lab work.</p> <p>An interview with the Administrator was held on 8/20/2025 at 3:40 PM, she revealed she was new to the facility and not sure who should have reported the blood draw results to the provider that ordered the labs.</p> <p>An interview was conducted with the Regional Nurse Consultant on 8/20/2025 at 3:50 PM. She revealed anyone could communicate the results of blood work but typically the unit manager would notify the prescribing provider of the results.</p>	F0773					

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F0773 <del>F0812</del> SS = E	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and staff interviews, the facility failed to ensure facial hair was covered during food preparation for 1 of 1 cook observation in the kitchen. This practice had the potential to affect food served to residents.</p> <p>Findings include:</p> <p>An observation was conducted on 8/18/2025 at 10:30am revealed the Cook was wearing a facial covering however his mustache and sides of his beard were exposed while preparing/cutting food.</p> <p>An interview was conducted on 8/18/2025 at 1:04pm with Dietary Manager Consultant revealed all staff should have a beard restraint that covered all facial hair.</p> <p>An interview was conducted on 8/21/2025 at 8:56pm with Administrator revealed that she was unaware that proper beard restraint was not practiced in the kitchen. She stated it was expected that all staff wear hair restraints and covered all facial hair while in the</p>		F0773 <del>F0812</del>				

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F0812 SS = E	Continued from page 47 kitchen and when preparing foods.	F0812					
F0880 SS = J	<p>Infection Prevention &amp; Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the</p>	F0880					



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F0880 SS = J	<p>Continued from page 48 least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, staff and Medical Director interviews, the facility failed to implement their infection control policies and procedures when Nurse #1 did not follow the manufacturer's instructions for cleaning and disinfecting a shared blood glucose meter (glucometer) before and after resident usage for 1 of 1 resident observed whose blood glucose (sugar) level was checked (Resident #34). On 8/20/25 Nurse #1 was observed obtaining Resident #34's blood glucose level followed by the nurse cleaning the glucometer with an alcohol wipe that was not an Environmental Protection Agency (EPA)-registered disinfectant. Nurse #1 then stated that she worked at the facility since March of 2025 and had always used an alcohol wipe to clean the glucometer indicating that she was unaware an EPA-registered disinfectant needed to be used. Resident #34 resided on the locked unit and this shared glucometer was utilized for 2 other residents (Residents #92 and #97) who resided on that unit. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an EPA-registered disinfectant in accordance with the</p>	F0880					

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F0880 SS = J	<p>Continued from page 49</p> <p>manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood-borne pathogens. There were no residents with a blood-borne pathogen in the facility at the time of the investigation. The facility staff also failed to change gloves between cleansing a wound and applying a new dressing and failed to perform hand hygiene between the removal of soiled gloves and the application of clean gloves (Wound Care Nurse). Finally, the facility failed to handle soiled linen in a manner that prevented the potential transmission of pathogenic (disease causing) microorganisms (germs) when Nurse Aide (NA) #2 placed soiled linen directly onto the floor. These deficient practices were identified for 3 of 10 staff members (Nurse #1, Wound Care Nurse, and NA #2) reviewed for infection prevention and control.</p> <p>Immediate Jeopardy began on 8/20/25 when Nurse #1 was observed performing a blood glucose check on Resident #34 using a shared glucometer without disinfecting per manufacturer's instructions. Immediate jeopardy was removed on 8/21/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for findings #2 and #3 and to ensure education is completed and monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>1. The blood glucose meter manufacturer's instructions for cleaning and disinfecting dated 09/2024 indicated the meter should be cleaned and disinfected after use on each patient with EPA-registered product. A list of EPA-registered products was listed in the instructions. Additional instructions were to read the manufacturer's instructions for the use of the EPA-registered cleaning and disinfecting product. Alcohol wipes were not listed as an EPA-registered product.</p> <p>Review of the facility policy "Glucometer Disinfection", undated, indicated that the objective was to prevent infection due to potential blood-borne pathogen exposure. The equipment and supplies were listed as gloves and germicidal disposable cloth/wipes. The procedure for disinfecting glucometers included:</p> <p>Step 1. Apply gloves</p>	F0880					

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F0880 SS = J	<p>Continued from page 50</p> <p>Step 2. When visible blood or body fluids are present, clean by wiping the external surfaces to remove any visible organic material. A cloth dampened with soap and water, or a germicidal wipe may be used according to the manufacturer's instructions and then discard.</p> <p>Step 3. After any visible blood or body fluids have been removed, or if no visible blood or bodily fluids are present:</p> <p>a.) Use EPA-registered germicidal disposable cloth/wipe horizontally and vertically to thoroughly wet the entire external surface of the glucometer according to the manufacturer's instructions.</p> <p>b.) Allow treated surface to remain wet for the germicidal wipe manufacturer's recommended exposure time. If needed, utilize a new germicidal wipe to keep the glucometer surface wet.</p> <p>Step 4. After allowing the full amount of exposure time according to manufacturer's product direction, discard the used cloth/wipe and allow the glucometer to thoroughly air- dry.</p> <p>Step 5. Remove and discard gloves. Perform hand hygiene.</p> <p>Step 6. When glucometer is completely dry, it may be used for the next resident or if not proceeding to another resident, store glucometer in med cart or specified storage area.</p> <p>A continuous observation of Nurse #1 was conducted on 8/20/25 from 12:36 PM through 12:51 PM revealed the following:</p> <p>On 8/20/25 at 12:36 PM, Nurse #1 was standing by the 500-hall medication cart in the day room of the locked unit with Resident #34 standing next to her. Nurse #1 took the glucometer out of the top left drawer of the cart where it had been stored. Nurse #1 put the glucometer on top of the cart, gathered supplies and obtained Resident #34's blood glucose. The Nurse was observed to clean the glucometer with a small alcohol wipe for less than one minute and place the glucometer</p>	F0880					

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F0880 SS = J	<p>Continued from page 51 back into the top left drawer of the medication cart. An EPA-registered container of wipes that was located on top of the medication cart indicated to disinfect nonfood contact surfaces; thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for blood-borne pathogen use.</p> <p>In an interview conducted with Nurse #1 during the observation that began on 8/20/25 at 12:36 PM she stated the glucometer was used on all residents in the locked unit that had orders for blood glucose testing. Nurse #1 further stated she had worked in the facility since March of 2025 and had always used an alcohol wipe to clean the glucometer. Nurse #1 indicated she had not been trained on how to disinfect the glucometer with an EPA-registered germicidal wipe.</p> <p>A follow-up interview was conducted with Nurse #1 on 8/20/25 at 1:37 PM. She revealed there was only one resident (Resident #34) who required blood glucose monitoring at lunchtime. Nurse #1 indicated she had completed three blood glucose checks before breakfast on 8/20/25 and used an alcohol wipe to clean the glucometer between each resident (Resident #34, Resident #92 and Resident #97).</p> <p>An interview on 8/20/25 at 12:54 PM with the Infection Preventionist (IP), who was also the Director of Nursing (DON), revealed each medication cart in the facility had one glucometer to be used for all residents on that hall that require blood glucose testing. The IP/DON indicated nurses should be cleaning and disinfecting the glucometers per manufacturer's instruction and facility policy. The IP/DON stated she was unsure what the facility policy on glucometer disinfection said. She indicated she was aware that improper disinfection of a shared glucometer could lead to blood-borne pathogens being transferred from one resident to another.</p> <p>A follow-up interview was conducted on 8/20/25 at 2:03 PM with the IP/DON. She stated there were no residents with known blood-borne pathogens in the facility.</p> <p>In an interview with the Administrator on 8/20/25 at 1:08 PM she indicated nurses should be disinfecting glucometers per manufacturer's instructions between each resident and before use if it is stored with other</p>	F0880					

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F0880 SS = J	<p>Continued from page 52 items such as in the medication cart drawer.</p> <p>A telephone interview was conducted on 8/21/25 at 8:50 AM with the Medical Director who stated the danger of not cleaning the shared glucometer per manufacturer's instructions was that blood-borne pathogens could be transmitted between residents. He indicated that all shared glucometers should be cleaned per manufacturers' instructions between residents and before use when the glucometer is stored with other items in a medication cart drawer.</p> <p>The Administrator was notified of immediate jeopardy on 8/21/25 at 9:30 AM.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:</p> <p>On 8/20/25, Nurse #1 removed a glucometer from the 500-hall (locked unit) medication cart drawer. Nurse #1 performed the blood glucose check on Resident #34 then wiped the glucometer with an alcohol wipe and placed the glucometer back into the medication cart drawer. Nurse #1 stated she was not aware she was to use an Environmental Protection Agency (EPA) germicidal approved wipe.</p> <p>On 8/20/25, the Facility Consultant completed a medical record audit of all residents, including Resident #34, Resident #92, and Resident #97, who received blood glucose checks. This audit was to identify any diagnosed blood-borne pathogen infections to ensure there were no infections related to improper cleaning and disinfecting of glucometers. No residents were identified with a blood-borne pathogen.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:</p> <p>On 8/20/25, the unit managers and the treatment nurse</p>	F0880					

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F0880 SS = J	<p>Continued from page 53</p> <p>completed the cleaning and disinfecting of all resident glucometers including Resident #34, Resident #92, and Resident # 97, in accordance with the manufacturer's instructions for cleaning and disinfecting glucometers. The instructions include utilizing an EPA-registered germicidal wipe, allowing full exposure time according to the manufacturer's product directions, then discarding the used wipe and allowing the glucometer to thoroughly air-dry before using it for the next resident.</p> <p>On 8/20/25, the Director of Nursing, Assistant Director of Nursing, Treatment Nurse and Unit Managers initiated, in person, education with all nurses to include Nurse #1 and medication aides regarding the importance of following facility and manufacturer's instructions for cleaning and disinfecting a shared glucometer including (1) using a EPA-registered germicidal disposable cloth/wipes (2) exposure times (3) dry time (4) the policy for cleaning and disinfecting glucometers (5) germicidal instructions for cleaning and disinfecting a glucometer are located on the container of the germicidal wipes (6) the risk factors of not properly cleaning shared glucometers. The in-service will be completed by 8/20/25. The Director of Nursing will monitor the completion of staff in-services. After 8/20/25, any nurse or medication aide who has not worked or received the in-service will receive the education prior to the next scheduled work shift. All newly hired nurses or medication aides including agency, will be in-serviced by the Director of Nursing, Assistant Director of Nursing or Unit Managers during orientation regarding the importance of following facility and manufacturer's instructions for cleaning and disinfecting a shared glucometer.</p> <p>On 8/20/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers initiated in-person return demonstrations of properly cleaning and disinfecting glucometers with all nurses to include Nurse #1 and all medication aides including agency. The purpose of the return demonstrations is to ensure that staff demonstrate knowledge and understanding of the glucometer cleaning and disinfecting procedures, including adhering to the manufacturer's instructions. Staff will be immediately retrained for any identified areas of concern. The return demonstrations will be completed by 8/20/25. Any nurse or medication aide who does not successfully pass the return demonstration will be immediately re-educated and will be required to repeat the return demonstration until successful demonstration is achieved. The return demonstrations</p>	F0880					

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F0880 SS = J	<p>Continued from page 54 were completed by 8/20/25 for all nurses and medication aides who worked. The Director of Nursing will monitor the completion of the glucometer cleaning return demonstrations. After 8/20/25, staff who have not completed the return demonstrations will complete it prior to their next scheduled work shift.</p> <p>On 8/20/25, the Director of Nursing, Assistant Director of Nursing and Unit Managers initiated in person quizzes with all nurses to include Nurse #1 and medications aides, including agency to validate knowledge and understanding of the importance of following facility and manufacturer's instructions for cleaning and disinfecting a shared glucometer. The quizzes included (1) how often do you need to clean a glucometer (2) what should you use to clean and disinfect a glucometer? (3) why is it important to follow the manufacturer's instructions to clean and disinfect a shared glucometer? (4) how do you know the exposure time for the disinfectant you are utilizing? Any nurse or medication aide that does not successfully pass the quiz will be immediately re-educated and will be required to retake the quiz at the time of administration until a successful passing score is achieved. The quizzes were completed by 8/20/25 for all nurses and medication aides who worked. The Director of Nursing will monitor the completion of staff quizzes. After 8/20/25, any nurse or medication aide who has not completed the quiz will complete it prior to their next scheduled work shift.</p> <p>Alleged immediate jeopardy removal date: 8/21/25</p> <p>A validation of immediate jeopardy removal plan was conducted on 8/22/25. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing, Assistant Director of Nursing or Unit Manager. An observation was conducted of glucose disinfection while onsite. The staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers.</p> <p>The immediate jeopardy removal date of 8/21/25 was validated.</p>	F0880					

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F0880 SS = J	<p>Continued from page 55</p> <p>2. A review of the facility policy titled "Handwashing Policy" revised 4/2023 provided by the facility revealed in part: "Personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. Personnel should wash their hands: ... When indicated between tasks and procedures to prevent cross contamination of different body sites."</p> <p>During observation on 8/20/25 at 11:29 AM the Wound Care Nurse was observed providing wound care to Resident #4. The wound care nurse was observed to perform hand hygiene and don personal protective equipment including gloves. The Wound Care Nurse was observed to cleanse the sacral wound with wound cleanser. After cleaning the wound, with the same gloves she cleansed the wound with, she then cut the xeroform (a non-adhering protective dressing) gauze to the size of the wound and placed the dressing over the wound bed. She then changed gloves, did not perform hand hygiene, and covered the xeroform gauze with a dry dressing.</p> <p>During an interview on 8/20/25 at 11:35 AM the Wound Care Nurse stated after cleansing the wound she should have performed hand hygiene and changed gloves prior to applying the xeroform gauze and dry dressing to prevent cross contamination and did not because she was nervous.</p> <p>During an interview on 8/20/25 at 11:38 AM the Director of Nursing stated hand hygiene, and a glove change should be performed between cleaning a wound and applying a new dressing to not cross contaminate the area being treated.</p> <p>3. A review of the facility's policy dated 3/10/2020 titled "Linen Handling Policy" revealed in part "All soiled linen should be considered contaminated. The risk of actual disease transmission from soiled linen with pathogenic (disease causing) microorganisms (germs) is insignificant if it is handled, transported, and laundered in a way that avoids the transfer of microorganisms. Soiled linen should be bagged or placed in containers at the location where it is used."</p> <p>On 8/18/25 at 2:55 PM soiled linen including towels and a gown were observed directly on the floor of Resident #1's room.</p> <p>On 8/18/25 at 2:58 PM an interview with Nurse Aide (NA) #2 outside the room indicated the soiled towels and gown where from the bathing she provided to Resident #1</p>	F0880					



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F0880 SS = J	<p>Continued from page 56</p> <p>at approximately 2:45 PM that day. She stated she should have placed these soiled items into a bag and not left them directly on the floor, but she did not. She indicated she had bags available and did not know why she had not done this. She reported she had been educated not to place soiled linen directly onto the floor in resident's room so that any germs on them did not get tracked around.</p> <p>On 8/22/25 at 11:25 AM an interview with the Director of Nursing (DON) indicated she also served as the facility's Infection Preventionist. She stated she was glad that NA #2 acknowledged that placing soiled linen directly on the floor in a resident's room was inappropriate, because this should never occur. She reported all soiled linen should be placed in bags. The DON stated this was for infection control purposes to prevent the spread of germs.</p> <p>On 8/22/25 at 11:38 AM an interview with the Administrator indicated soiled linen should be bagged at the time of removal and never placed directly on the floor.</p>		F0880				