STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115681	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Old Capitol	310 Highway #1 Bypass Louisville, GA 30434

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 40824 Based on resident and staff interviews, review of Resident Council Minutes, and review of the facility policy titled, Patient/Resident Council, the facility failed to ensure a response was provided to the members of the resident council when concerns were identified related to transportation accommodations for outings. During the resident council meeting four residents (R) (R30, R36, R54, and R78) had complaints of transportation not being provided for outings and had not received a response. Findings include: Review of documentation provided by the facility titled Patient/Resident Council Minutes/Report Form, from 8/29/2022 to 4/22/2024, included Old Business/Resolutions [store name] trip is on hold due to [transportation company name] does not have van available at this time. Vans is in shop & [sic] also have wrecked vans. Ongoing trip to [store name] pending a van for transportation. During a Resident Council Meeting held on 5/21/2024 at 10:30 am, R30, the Resident Council President stated that residents wanted to take trips, they want a van for transportation, and the Activities Director keeps telling them They're working on it. R30 reported this had been going on for over a year. R36, R54, and R78 confirmed the group had been requesting to go on outings to [store name] and to go out to eat. Additionally, they were told that if they did a van rental, it would cost 20 dollars per person, but have not been given the opportunity to go, and no response had been provided. During an interview on 5/22/2024 at 2:20 pm, the Director of Nursing (DON) stated that the facility did not have their own transportation vehicle, but the facility had a contract with a transportation company to provide transportation for medical appointments, but no transportation was available for outings. The DON was aware that the Resident Council members wanted to go on outings but was unaware if a response had been provided to the residents. During an interview on 5/22/2024 at 4:13 pm, the Social Services Director (SSD) confirmed the Resident Council concern regarding outings had been raised during morning meetings. The facility had discussed borrowing a van from another sister facility, but a response had not been provided that she was aware of. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/2024 at 4:35 pm, the Activities Director (AD) confirmed that the Resident Council group members had been asking for transportation for outings to [store name] for quite some time. Additionally, prior to COVID-19 the facility contracted with [transportation company name] for transportation for outings, then once COVID-19 happened, the outings stopped. AD stated that she had spoken with a supervisor at [transportation company name] who told her that there were new rules and no drivers. The facility had also reached out to other sister facilities to borrow a van but were told the vans were already booked and unavailable. Her practice had been to notify the Administrator of the transportation requests, the Administrator signs off on all Resident Council meeting minutes, but no resolution/response had been made. During an interview on 5/23/2024 at 8:21 am, the Administrator stated that she was aware that one resident wanted to go to [store name], but the facility did not provide transportation for outings. In the past, the facility had contacted [transportation company name] and was unable to get an agreement for the transportation company to take the residents on outings. The Administrator confirmed that this information was not conveyed to the residents. During an interview on 5/23/2024 at 2:00 pm, the Ombudsman stated that she had been to several Resident Council meetings and was aware that the residents had voiced requests for transportation for outings. She had advocated on behalf of the residents to the [Coalition group name], but no resolution had been provided to the residents that she was aware of. A review of the facility policy titled Patient/Resident Council, revised 10/20/2017, stated A Patient/Resident Council will be developed and supported by the administration. 2. Issues raised/discussed, and recommendations made by the Patient/Resident Council will be communicated to the healthcare center administration, considered in center planning, and responded to promptly. 3. The Recreation Services Director or Social Services Director will assist in the coordination of the council meetings as requested by the group President and provide assistance as needed in documentation of minutes and serving as liaison with the healthcare center administration in responding to issues that result from group meetings .10. Issues, concerns, ideas, or complaints of the Council will be transferred to the Patient/Resident Council/Family Council Department Response Form by the staff liaison person and given to the Administrator for distribution and response by the appropriate department. The response/action will be documented on this form, returned to the Administrator for review and signature and returned to the Council staff liaison for communication back to the Council Presiding Officer and presentation at the next council meeting. The department response form will be attached to the minutes of the meeting in which the issues was brought up .

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interviews, record review, and a review of the facility policy titled Facility Assessment Tool, the facility failed to provide education for all nursing staff to possess the competencies and skill sets necessary to ensure residents were free of medication errors as well as ensure these competencies and skill sets were monitored on an ongoing basis. As a result, one of 26 residents (Resident (R) 50) out of a total sample of 83 residents was hospitalized after a nurse administered a benzodiazepine (an antianxiety drug that can cause sedation), which was not ordered by the physician, to the resident. The facility's failure to provide education for all nursing staff to possess the competencies and skill sets necessary to ensure residents were free of medication errors as well as ensure these competencies and skill sets were monitored on an ongoing basis presented a likelihood of serious harm, injury, impairment, or death due to the significant medication error for R50. Immediate Jeopardy was identified on 5/22/2024 in the area of S483.35 Nursing Services F726 at a scope and severity (S/S) of J. The Administrator and Director of Health Services (DHS) were informed on 5/23/2024 at 9:13 am that the Immediate Jeopardy existed related to the failure to ensure nursing staff were educated on the facility's medication administration policy, competency assessments were conducted on medication administration, and monitoring was completed to ensure nursing staff were properly administering medications according to the policy. The Immediate Jeopardy began on 3/29/2024, the date R50 was administered the benzodiazepine and was admitted to the hospital. Cross reference F760-J: Residents are free of Significant Medication Errors Findings include: A review of R50's undated Face Sheet, located in the Electronic Medical Record (EMR) under the Face Sheet tab, revealed R50 was admitted to the facility on [DATE] with multiple diagnoses including Parkinson's disease with dyskinesia and chronic diastolic (congestive) heart failure. A review of R50's Nursing Progress Notes, dated 3/29/2024 and located under the Progress Notes tab of the EMR, revealed, . Resting in bed respiration even and unlabored difficult to arouse requiring chest stimulation to respond skin w/d [warm/dry] to touch verbal response with slow sluggish speech. A review of R50's Hospital Discharge Summary, dated 3/31/2024 and located in the EMR under the Resident Documents tab, revealed . [R50] was admitted on [DATE] from local nursing home due to altered mental status. Patient had been unresponsive with pinpoint pupils given intranasal Narcan and became more responsive temporarily, then unresponsive upon arrival to the ED [emergency department]. Urine drug screen did show benzodiazepines . A review of R14's (R50's roommate) Physician's Orders, dated 7/7/2021 and located under the Orders tab of the EMR, revealed an order for alprazolam (a benzodiazepine) 0.5 milligrams (MG) tablet one tablet by mouth two times a day at 9:00 am and 9:00 pm for anxiety. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/23/2024 at 6:04 pm, the former Clinical Competency Coordinator (CCC) confirmed her role included providing education for all nursing staff to possess the competencies and skill sets necessary to provide nursing care and to monitor the competencies and skill sets on an ongoing basis. The CCC stated nursing staff completed training, competency assessments were conducted upon hire, and annual training included a skills fair and medication administration questionnaire on the computer. The CCC acknowledged she had not conducted medication administration observations of the nursing staff until after the incident occurred when R50 received the wrong medication which was reported to the facility by R50's family member. The CCC indicated after she identified that Licensed Practical Nurse (LPN) 1 was not administering medications per the policy, all nursing staff were educated on how to properly administer medications from 4/2/2024 to 4/5/2024. During an interview on 5/23/2024 at 8:01 pm, the Administrator stated she expected the CCC to provide nursing staff training on medication administration per the policy, identify medication administration errors, and work with the DHS to correct those errors. During an interview on 5/24/2024 at 9:39 am, the DHS confirmed the CCC was training nursing staff on medication administration at the skills fair, and nursing staff were completing a medication administration test on the computer annually. The DHS stated medication administration observations of the nursing staff were not completed on an ongoing basis until after R50's medication error. During an interview on 5/24/2024 at 11:46 am, LPN1 confirmed she prepared R14's medications, placed them in a cup, prepared R50's medications, and then placed them in a cup without labeling the cups at the medication cart. LPN1 stated she placed R50's medications on a tray, held R14's cup of medications in her right hand, and then took them to their shared room and administered them to the residents. LPN1 also stated that she had been administering the residents' medications this way for approximately one year because the residents had more medications to administer, and it was convenient to use the tray to pass them. LPN1 indicated she received training on medication administration at the annual skills fair, completed a medication administration test on the computer, and a medication administration observation was conducted in April 2024 by the CCC. A review of the facility-provided document titled, Facility Assessment Tool, dated April 2024, revealed . 2. Staff training and competency-Annual competencies and based on guest acuity. Utilize [NAME] and Relias for training. Head to toe assessments during orientation . A review of the facility-provided position description titled, RN - Clinical Competency Coordinator, revealed . Key Responsibilities . 5. Implement and oversees the healthcare centers orientation program for new partners and recommends progression to permanent employment or extension of the orientation probationary periods, as well as baseline, annual, and on-going clinical competency evaluation of nursing partners . 29. Completes initial competency assessment of clinical staff upon hire, annually and as needed . 3l. Conducts competency assessments to determine partner learning needs based on patient conditions and acuity . 37283

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on resident and staff interviews, record review, and a review of the facility policy titled Medication Administration: Oral Medications, the facility failed to ensure residents were free from significant medication errors for one of 26 sampled residents (Resident (R) 50) out of 83 total residents. R50 received a benzodiazepine (an antianxiety drug that can cause sedation), that was not ordered by the physician and contributed to her hospitalization . The facility's failure to ensure residents were free from significant medication errors presented a likelihood of serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 5/22/2024 in the area of S483.45 Pharmacy Services F760 at a scope and severity (S/S) of J. The Administrator and Director of Health Services (DHS) were informed on 5/22/2024 at 2:50 pm that the Immediate Jeopardy (IJ) existed related to the failure to ensure residents were free from significant medication errors for one resident. The Immediate Jeopardy was determined to exist on 3/29/2024, the date R50 received the benzodiazepine and was admitted to the hospital. The facility failed to provide a Removal Plan, and the IJ at F760 was ongoing at the time of the survey exit on 5/23/2024. Findings include: A review of R50's undated Face Sheet, located in the Electronic Medical Record (EMR) under the Face Sheet tab, revealed R50 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, Parkinson's disease, major depressive disorder, hypertensive heart disease, and type two diabetes. R50 had no known drug allergies. R50 was hospitalized from 3/29/2024 to 3/31/2024. A review of R50's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/7/2024 and located in the EMR under the MDS 3.0 Assessments tab, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating R50 was moderately cognitively impaired. It was recorded that R50 received insulin injections, diuretics, and antiplatelets in the preceding seven days. A review of R50's Physician's Orders, located in the EMR under the Orders tab, revealed no orders for benzodiazepines. A review of R50's MARs, dated March 2024, revealed that R50 was administered her ordered medications on 3/29/2024 at 9:00 am. These ordered medications did not include benzodiazepines. A review of R50's Nursing Progress Notes, dated 3/29/2024 and located under the Progress Notes tab of the EMR, revealed, . Resting in bed respiration even and unlabored difficult to arouse requiring chest stimulation to respond skin w/d [warm/dry] to touch verbal response with slow sluggish speech. V/S [vital signs] 142/52-46-22-97.1-94%. BS [blood sugar] 236 after meal 11:30 am 151 insulin given as ordered. [R50's physician] updated on status, order to send to Emergency Department (ER) . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R50's Hospital Discharge Summary, dated 3/31/2024 and located in the EMR under the Resident Documents tab, revealed, . [R50] was admitted on [DATE] from local nursing home due to altered mental status. Patient had been unresponsive with pinpoint pupils given intranasal Narcan and became more responsive temporarily, then unresponsive upon arrival to the ED [emergency department]. R50 was given additional doses of Narcan and Romazicon (drug used to treat drowsiness caused by sedatives) and is now alert and oriented this morning. She does not remember the events that led up to last night. Urine drug screen did show benzodiazepines . A review of R14's (R50's roommate) Physician's Orders, dated 7/7/2021 and located under the Orders tab of the EMR, revealed an order for alprazolam (a benzodiazepine) 0.5 milligrams (MG) tablet one tablet by mouth two times a day at 9:00 am and 9:00 pm for anxiety. A review of the facility's investigative documents revealed the following nursing staff statements written on 4/4/2024: Licensed Practical Nurse (LPN) 1: On 3/29/2024 at 1:00 pm, LPN1 was notified by Certified Nursing Assistant (CNA) 1 that R50 did not eat lunch, so she checked on her and found that she was responsive but lethargic. At 4:45 pm, R50 was difficult to arouse when checking her blood sugar. LPN1 contacted R50's physician and received orders to send R50 to the hospital ED for evaluation and treatment. LPN1 stated the only medications that she gave R50 were the medications ordered by R50's physician. CNA1: On 3/29/2024, R50 was kind of drowsy and fatigued. She would respond with a moan but would go back to sleep. She reported this to LPN1. LPN1 assessed R50 then other nurses entered R50's room. CNA2: On 3/29/2024, she witnessed R50 acting strangely. When she called R50's name, she moaned but did not open her eyes. LPN1 was already informed so she asked her to get another nurse. The nurses assessed R50. During an interview on 5/20/2024 at 9:53 am, R50 stated she remembered that she was given a medication by the nurse that made her sleepy, and then she woke up in the hospital the next day. During an interview on 5/21/2024 at 8:22 pm, the Pharmacy Consultant stated he was contacted by the Director of Health Services (DHS) on 4/4/2024 regarding benzodiazepines showing up in R50's urinalysis and determined after review of R50's medication orders that none of them would show a false positive result for benzodiazepines. The Pharmacy Consultant also stated the medication error was reported to him and that R50's roommate and residents across the hallway were ordered benzodiazepines. During an interview on 5/23/2024 at 6:04 pm, the Clinical Competency Coordinator (CCC) acknowledged that upon investigation of R50 receiving the wrong medication, she observed LPN1 preparing medications for more than one resident at a time at the medication cart, placing all the medications on a tray, taking the medications into the room for more than one resident, and administering medications to both residents on the same trip into the room. The CCC stated this medication administration practice created a potential for residents to receive medications meant for another resident. During an interview on 5/24/2024 at 8:17 am, the Medical Director (MD) confirmed he was notified of the medication administration error that occurred on 3/29/2024 for R50 by the Director of Health Services (DHS). The MD stated that when residents received the wrong medications, it could result in serious harm or death. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/24/2024 at 9:39 am, the DHS stated that R50's family member reported the medication error to the facility when it was discovered during the hospitalization . The DHS also stated that the CCC identified the medication administration error during a medication administration observation of LPN1 on 4/2/2024. The DHS confirmed she had observed LPN1 using a tray to pass medications last year, and LPN1 told her that she only used it to carry inhalers and insulin pens, so she did not stop the practice. The DHS confirmed the medication administration practice used by LPN1 could have caused serious injury or death to R50. During an interview on 5/24/2024 at 11:46 am, LPN1 confirmed she prepared R14's medications, placed them in a cup, prepared R50's medications, and then placed them in a cup without labeling the cups at the medication cart. LPN1 stated she placed R50's medications on a tray, held R14's cup in her right hand, and then took them to their shared room and administered them to the residents. LPN1 stated that she had been administering the residents' medications in this manner for approximately one year because the residents had more medications to administer, and it was convenient to use the tray to pass them. LPN1 indicated the CCC provided medication administration training at the annual skills fair and performed a medication administration observation in April 2024. A review of the facility's policy titled, Medication Administration: Oral Medications, revised 12/10/2021 and provided by the facility, revealed, Policy: It is the policy of the facility that oral medications are administered in an organized and safe manner . Special considerations: . Only one patient/resident's medication at a time should be prepared for administration. Procedure & Key Points: 1. Bring a medication cart in the vicinity of the patient/resident's room. Verify that the patient/resident is in the room . 5. Read and compare the medications with the MAR [Medication Administration Record] and EMAR [Electronic Medication Administration Record]. 6. Place the medication into a souffle cup . 10. Identify patient/resident before administering medication . 37283

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28604 Based on observations, staff interviews, and review of the facility policy titled Controlled Substances for Healthcare Centers, the facility failed to ensure that controlled medications (drugs that can cause physical and mental dependence and have restrictions on how they can be filled and refilled) were stored separately from other medications and were stored under a double-lock system in two of two medication storage room refrigerators. Findings include: Observation on 5/21/2024 at 9:18 am of the East Wing medication room, which was located behind the nurses' station, with Licensed Practical Nurse (LPN) 1 revealed the locked refrigerator in the medication storage room contained the following medications: 1. One Novolog insulin aspart flexpen for Resident (R)13. 2. One Levemir insulin flexpen for R22. 3. One Levemir insulin flexpen for R37. 4. One Novolog insulin flexpen and two Lantus Solostar insulin pen for R41. 5. Three Novolog insulin aspart flexpens for R31. 6. Four Novolog insulin aspart flexpens and one injection of Aranesp (a drug used to treat anemia) for R61. 7. Two injections of Risperdal (drug used to treat schizophrenia) Const for R8. 8. One bottle of Lorazepam Intensol Oral Concentrate (Schedule IV controlled medication) for R71. 9. One bottle of Lorazepam Intensol Oral Concentrate for R77. The controlled medications were not stored separately from any other medications and were not stored using a double-lock system. Observation on 5/21/2024 at 9:28 am of the [NAME] Wing medication room, which was located behind the nurse's station, with LPN2 revealed the locked refrigerator in the medication storage room contained the following medications: 1. One Novolog insulin aspart flexpen for R12. 2. One Fiasp insulin flextouch pen and one box of Lokelma (a drug used to treat high potassium levels) containing 14 packets for R25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. One box of Dupixent (a drug used to treat eczema) containing two pens for R42. 4. One box of Veltassa (a drug used to treat high potassium levels) containing 12 packets for R58. 5. One bottle of lorazepam (a drug used to treat anxiety) oral concentrate (Schedule IV controlled medication), for R1. The controlled medications were not stored separately from any other medications and were not stored using a double-lock system. During an interview on 5/21/2024 at 9:44 am, the Director of Health Services (DHS) acknowledged she was not aware that the controlled medications had to be stored separately from all other medications. The DHS stated the Pharmacy Consultant audited their medication rooms monthly and found no errors. During an interview on 5/21/2024 at 10:38 am, the Pharmacy Consultant confirmed the controlled medication policy stated controlled medications, Schedule II through V medications, were stored from other medications, but he had not seen them. The Pharmacy Consultant acknowledged he audited the medication rooms monthly but ensured the controlled medications were stored separately had not been completed because the task was not listed on the audit tool. A review of the facility's policy titled Controlled Substances for Healthcare Centers, revised 4/28/2021, revealed, . Storage: Controlled substances in Schedules II, III, IV, and V are stored under double lock in a locked cabinet or safe designated for that purpose and separate from all other medications .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37283 Based on observations, staff interviews, and review of the facility policy titled Labeling, Dating, and Storage, the facility failed to ensure food items were securely closed, labeled, and dated after opening. This had the potential to affect 75 of 83 residents who consumed food from the kitchen. Findings include: 1. During observation and initial kitchen walk-through with the Dietary Manager (DM) on 5/20/2024 beginning at 9:35 am, the following was observed and confirmed by the DM: a. In the dry storage room, there was a one-pound bag of macaroni spiral pasta, open to air, undated and unlabeled. b. In the dry storage room, there was an opened bag of cookies (removed from the original container) that was undated and unlabeled. c. In the walk-in cooler, there were 15 cups of juice in cups that were undated and unlabeled. 2. During a second kitchen walkthrough on 5/21/2024 at 8:48 am with the DM, the following was observed and confirmed by the DM: a. In the walk-in cooler, there was a one-gallon container of ranch dressing that was open, undated, and unlabeled. b. In the walk-in cooler, there was one pound of butter that was open, undated, and unlabeled. During an interview on 5/21/2024 at 10:55 am, the DM stated she expected all foods to be stored properly, including being dated and labeled as required. During an interview on 5/23/2024 at 3:30 pm, the Administrator stated she expected the staff to follow policy, label with appropriate dates, and store food items properly. A review of the facility's undated policy titled Labeling, Dating, and Storage indicated. Food and beverage items will have an identifying label as well as a received date and opened date, as applicable; for items prepared on site, a 'use by' date will also be indicated. Foods will be stored in their original or approved container and, if opened, shall be wrapped tightly with film, foil, etc .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interviews, facility policy reviews, and job description reviews, the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to avoid significant medication errors during nursing medication administration. The facility failed to provide continued, effective oversight of the nursing staff's medication administration practices. This failure affected one of 26 residents out of 83 total residents (Resident (R) 50) when R50 received a benzodiazepine (an antianxiety drug that can cause sedation), which was not ordered by the physician and contributed to R50 hospitalization . The failure of the facility to provide continued, effective oversight of nursing staff's medication administration practices presented a likelihood of serious harm, injury, impairment, or death due to the significant medication error for R50. Immediate Jeopardy was identified on 5/22/2024 in the area of S483.70 Administration F835 at a scope and severity (S/S) of J. The Administrator and Director of Health Services (DHS) were informed on 5/23/2024 at 9:13 am that the Immediate Jeopardy existed related to the failure to provide continued, effective oversight of nursing staff's medication administration practices. The Immediate Jeopardy (IJ) was determined to exist on 3/29/2024, the date R50 received the benzodiazepine and was admitted to the hospital. The facility failed to provide a Removal Plan, and the IJ at F835 was ongoing at the time of the survey exit on 5/23/2024. Cross reference F760-J: Residents are free of Significant Medication Errors Findings include: During an interview on 5/23/2024 at 6:04 pm, the former Clinical Competency Coordinator (CCC) confirmed her role included providing education for all nursing staff to possess the competencies and skill sets necessary to provide nursing care and to monitor the competencies and skill sets on an ongoing basis. The CCC also stated nursing staff completed training, competency assessments were conducted upon hire, and annual training included a skills fair and medication administration questionnaire on the computer. The CCC acknowledged she had not conducted medication administration audits of the nursing staff until R50's family member reported R50 had received the wrong medication, which contributed to R50 hospitalization from [DATE] to 3/31/2024. The CCC indicated the medication administration audits revealed Licensed Practical Nurse (LPN) 1 was not administering medications per the medication administration policy. During an interview on 5/23/2024 at 8:01 pm, the Administrator stated she was responsible for the overall management of the facility and expected the CCC to provide nursing staff training on medication administration per the policy, identify medication administration errors, conduct ongoing medication administration audits, and collaborate with the DHS to correct any identified errors. The Administrator also stated she was notified by R50's family member on 4/1/2024 that the hospital staff told her that the resident received the wrong medication on 3/29/2024, and it contributed to her hospital admission. The Administrator indicated that upon investigation of the incident, the CCC identified through medication administration observations that LPN1 was preparing the medications at the same time and then passing them to the residents in their rooms at the same time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115681	A. Building B. Wing	05/23/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/24/2024 at 9:39 am, the DHS confirmed the CCC provided training to the nursing staff on medication administration at the annual skills fair, and nursing staff completed a medication administration test on the computer annually. The DHS stated the investigation of the incident for R50 revealed medication administration audits had not been conducted on a continuous basis to monitor the nursing staff's knowledge and performance of the task. A review of the facility-provided job description titled, Director of Health Services, revealed, . Job Purpose: Plans, organizes, develops and directs the overall operation of our Nursing Services Department in accordance with current federal, state, and local regulations governing our nursing center, and as may be directed by the Administrator and the Medical Director, to provide appropriate care . A review of the facility-provided position description titled, RN [Registered Nurse] - Clinical Competency Coordinator, revealed, . Key Responsibilities . 5. Implement and oversees the healthcare centers orientation program for new partners and recommends progression to permanent employment or extension of the orientation probationary periods, as well as baseline, annual, and on-going clinical competency evaluation of nursing partners . 29. Completes initial competency assessment of clinical staff upon hire, annually and as needed . 3l. Conducts competency assessments to determine partner learning needs based on patient conditions and acuity . A review of the facility's policy titled, Medication Administration: Oral Medications, revised 12/10/2021 and provided by the facility, revealed Policy: It is the policy of the facility that oral medications are administered in an organized and safe manner . Special considerations: . 8. Only one patient/resident's medication at a time should be prepared for administration. Procedure & Key Points: 1. Bring medication cart in the vicinity of the patient/resident's room. Verify that the patient/resident is in the room . 5. Read and compare the medications with the MAR and EMAR. 6. Place the medication into a souffle cup . 10. Identify patient/resident before administering medication . 37283

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 30347 Based on interview, review of facility documentation, and review of facility policy, the Quality Assurance and Performance Improvement (QAPI) committee failed to ensure it developed and maintained a program to provide systematic analysis and systemic action aimed at performance improvement. This failure had the potential to affect all 83 residents who currently live in the facility. Findings include: Review of the facility policy titled, [Company Name] Skilled Nursing and Rehabilitation Center Quality Assurance and Performance Improvement (QAPI), dated 02/26/2016, revealed, Policy Statement: The purpose of Quality Assurance and Performance Improvement (QAPI) Program at [Company Name] is to continually take a proactive approach to assure and improve the way we provide care and engage with our patients, partners and other stakeholders so that we may fully realize our vision, mission and commitment to caring pledge. Scope: This policy applies to [Company Name] Skilled Nursing and Rehabilitation Centers (SNRC) and partners as part of the overall QAPI Plan .Procedure: All [Company Name] partners and contracted staff are responsible for the quality of care and services within their respective departments and are expected to participate in the QAPI Program. Each Center must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. It is the expectation of the [Company Name] SNRC QAPI Program that each location will follow the established QAPI process in order to guide and direct the operations of that location . [Company Name] SNRC Standardized QAPI Tools Include: A standard Meeting Minutes template was designed based on the agenda, which will be maintained on the Regional SharePoint site to allow communication with the Regional team . The Quality Management System which is the software program utilized to document Performance Improvement Projects (PIP's) and an overview of the root cause analysis completed. Performance Improvement Projects (PIPs): As part of its QAPI Program, each [Company Name] SNRC develops, implements, and evaluates performance improvement projects. The facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the center must reflect the scope and complexity of the facility's services and available resources. a Performance Improvement projects must include at least annually a project that focuses on high risk, high volume or problem-prone areas for improvement identified through the data collection and analysis based on: Feedback an input from stakeholders; Data/metrics reported monthly from all departments; Adverse event monitoring and investigation/analysis . Documentation of the [Company Name] QAPI Program includes: All performance improvement projects being conducted; The reasons for conducting these projects; Measurable progress achieved during performance improvement projects; Evidence that demonstrates the operation of the center's QAPI Program . An attempt was made to review the meeting minutes and Performance Improvement Projects (PIP) for the previous four quarters. There was no documentation available for review. There was no documentation indicating the facility had been working to identify areas of concern for improvement or to determine the underlying causes of any problems. There was no documentation of current PIPs, or any PIPs having been completed and reviewed by the facility. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the QAPI interview on 05/23/2024 at 5:15 pm, the Administrator stated, There are no sign-in sheets and no meeting minutes to review. We don't have formal minutes of the meetings. We don't have any records of who was there or what we talked about. There are no PIPs in progress or records of any that have been completed.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 30347 Based on interview, review of facility documentation, and review of facility policy, the Quality Assurance and Performance Improvement (QAPI) committee failed to ensure the required members of the committee attended the quarterly meetings. This failure had the potential to affect all 83 residents who currently live in the facility. Findings include: Review of the facility policy titled, Skilled Nursing and Rehabilitation Center Quality Assurance and Performance Improvement (QAPI), dated 02/26/2016, revealed, Policy Statement: The purpose of Quality Assurance and Performance Improvement (QAPI) Program at [Company Name] is to continually take a proactive approach to assure and improve the way we provide care and engage with our patients, partners and other stakeholders so that we may fully realize our vision, mission and commitment to caring pledge. Scope: This policy applies to [Company Name] Skilled Nursing and Rehabilitation Centers (SNRC) and partners as part of the overall [Company Name] QAPI Plan .Procedure: All [Company Name] partners and contracted staff are responsible for the quality of care and services within their respective departments and are expected to participate in the [Company Name] QAPI Program. Each Center must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. It is the expectation of the [Company Name] SNRC QAPI Program that each location will follow the established QAPI process in order to guide and direct the operations of that location .Communication: The Center Quality Assurance and Assessment (QAA) committee is required to use the established QAPI Meeting Minutes for documenting and communicating QAPI efforts required to the regional committee level. The corporate and regional committees should communicate their efforts to the level below them to ensure all committees are working cohesively. [Company Name] SNRC Standardized QAPI Tools Include: A standard Meeting Minutes template was designed based on the agenda, which will be maintained on the Regional SharePoint site to allow communication with the Regional team. This template also includes a sign in sheet that should be printed and utilized in each center's monthly meeting. An attempt was made to review the sign-in sheets for the previous four quarters. There were no sign-in sheets available for review. There was no documentation indicating who attended any of the meetings or to confirm that the meeting occurred. During the QAPI interview on 05/23/2024 at 5:15 pm, the Administrator stated, The QAPI committee meets at least quarterly but, normally we meet monthly. The Medical Director, Director of Health Services (DHS), myself, the Infection Preventionist (IP), and department heads normally attend the meetings. There are no sign-in sheets and no meeting minutes to review. We don't have formal minutes of the meetings. We don't have any records of who was there or what we talked about.