STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115775	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Village - Athens	1400 Live Oak LN Bldg 100 Athens, GA 30606

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 37739 Based on record review, interview, and review of the facility policy titled Abuse/Neglect Prevention Program, the facility failed to ensure employee screening including a criminal background check was received prior to hiring one of 11 employees (Dietary Manager) reviewed for background screening requirements. Findings included: A review of the Abuse/Neglect Prevention Program dated 9/29/2023 revealed that an aggressive abuse prevention program will be implemented in order to identify potential persons capable of abusive behavior prior to hiring. Hiring Practices/Screening: A. This facility will conduct thorough investigation histories of individuals being considered for hire . We will check references and perform criminal background checks. Review of the employee file for the Dietary Manager indicated the date of hire was 1/28/2021. The Georgia Criminal History Check System (GCHEXS) background screening was received by the facility on 5/18/2021. During an interview on 7/21/2024 at 11:35 am, the Director of Human Resources (DHR) confirmed that there are some employees that have a hire date prior to receiving their GCHEXS background screening. She stated that as long as the facility completes a local background screening, they can be hired before receiving the GCHEX Satisfaction Letter.

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

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

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44960 Based on record review, interviews, and review of the facility's document titled Bed Hold Letter, the facility failed to ensure written notice of the bed-hold was provided to the resident or residents' representative upon transfer to the hospital for one of two residents (R) (R20) reviewed for hospitalization . This failure had the potential to contribute to possible denial of re-admission following hospitalization for residents discharged emergently to the hospital. Findings include: Review of an undated document provided by the facility, titled Bed Hold Letter revealed that Medicare and private insurance companies will not pay to hold the bed at the nursing facility while the resident is hospitalized . The family may hold the bed by paying the private room rate. If you decide not to hold the bed, the facility will assign the bed to a new resident. Upon discharge from the hospital, the resident can be readmitted if a bed is available. Review of the medical record revealed R20 was admitted to the facility on [DATE] with diagnoses including intracranial hemorrhage, hypertension (HTN), Alzheimer's disease, metabolic encephalopathy, and stage 3 chronic kidney disease. He was transferred to the hospital on 2/3/2024, with return anticipated. There was no evidence in the medical record that resident or his representative was provided with information regarding the facility's process for bed hold. The resident returned to the facility on [DATE]. Interview on 7/22/2024 at 3:12 pm, the Social Services Director (SSD) stated she wasn't sure who prepared the Bed Hold Letter and sent it to the resident or his/her representative. She stated she had not been keeping a log or other means to ensure this requirement was met. During further interview, the SSD stated the facility does not have an in-house business office manager, and she had been informed that it would be her responsibility or the responsibility of the admissions coordinator to implement the bed-hold policy going forward.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38997 Based on record review, interviews, and review of the policy titled Care Plans - Comprehensive, the facility failed to develop and/or implement a person-centered care plan for five of 20 sampled residents (R) (R5, R15, R19, R20, and R12). Specifically, the facility failed to develop a comprehensive care plan for R5 related to pressure ulcer/injury, psychotropic drug use, activities of daily living (ADL) care, and urinary incontinence; R15 related to cognitive loss/dementia, communication, ADL care, urinary incontinence, and risk of pressure ulcer/injury; R19 related to anticoagulant therapy, pain, psychotropic drug use, risk for pressure ulcer, hospice, behavioral symptoms, ADL care, dementia, or delirium; R20 related to the diagnosis of delirium, cognitive loss/dementia, ADL care, urinary incontinence, pressure ulcer/injury, and psychotropic drug use; and R12 related to diagnosis of Alzheimer's and dementia. This deficient practice placed the residents at risk for unmet care needs. Findings include: A review of the undated policy titled Care Plans-Comprehensive revealed the Policy: Number 1. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs is developed for each resident. Number 2. The facility's care planning/Interdisciplinary team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident me be expected to attain. Number 3. The comprehensive care plan is based on a thorough assessment that includes but is not limited to, the Minimum Data Set (MDS) assessment. Number 4. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect the resident's expressed wishes regarding care and treatment goals; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; i. Reflect currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Number 6. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident. Number 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the residents condition change. 37739 1. A review of the electronic medical record (EMR) revealed that R5 was admitted to the facility on [DATE] with diagnoses including neuropathic bladder, orthostatic hypotension, gastroesophageal reflux disease (GERD), muscle weakness, and depression. A review of the Annual Minmum Data Set (MDS) assessment dated [DATE] revealed that R5 presented with a Brief Interview for Mental Status (BIMS) of 14, indicating no cognitive impairment. A review of the Care Area Assessment (CAA) revealed R5 triggered for functional abilities (self-care and mobility), urinary incontinence and indwelling catheter, falls, nutritional status, pressure ulcer/injury, and psychotropic drug use. A review of the July 2024 Order Summary Report revealed that R5 was ordered to receive escitalopram 10 mg tablet one time a day related to depression, with start date of 4/3/2024. A review of the care plan for R5 dated 4/8/2024 revealed no focus area for risk of pressure ulcer/injury, psychotropic drug use, functional abilities (self-care and mobility), or urinary incontinence. 2. A review of the EMR revealed that R15 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), dysphagia, cognitive communication deficit, chronic diastolic (congestive) heart failure, hypertension, irritable bowel syndrome (IBS), hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage, and acute embolism and thrombosis of other specified deep vein of unspecified lower extremity. A review of the Quarterly MDS assessment dated [DATE] revealed that R15 presented with a BIMS of three, indicating severe cognitive impairment. A review of the CAAs revealed that R15 triggered for cognitive loss/dementia, communication, functional abilities (self-care and mobility), urinary incontinence and indwelling catheter, and risk of pressure ulcer/injury. A review of the care plan initiated on 6/11/2024 for R15 revealed no care plan for cognitive loss/dementia, communication, functional abilities (self-care and mobility), urinary incontinence and indwelling catheter, and risk of pressure ulcer/injury. 3. A review of the EMR revealed that R19 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease, chronic diastolic (congestive) heart failure, atrial fibrillation, hypertension (HTN), acute embolism and thrombosis of the lower extremity, pulmonary embolism, dementia with behavioral disturbance, and diabetes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the quarterly MDS assessment dated [DATE] revealed that R19 received antidepressant, anticoagulant, diuretic, opioid, and hypoglycemic medications during the look back period. A review of the CAAs revealed that R19 triggered for delirium, cognitive loss/dementia, functional abilities (self-care and mobility), behavioral symptoms, pressure ulcer/injury, psychotropic drug use, and pain. A review of the July 2024 Order Summary Report revealed that R19 was ordered to receive lorazepam (medication to treat anxiety) 0.5 mg tablet one tablet by mouth every two hours as needed (PRN) for anxiety/agitation; morphine sulfate (medication to treat pain) oral solution 100 mg/5ml - give 1 ml (milliliter) by mouth every hour PRN for pain (7-10), 0.5 ml by mouth every hour PRN for pain (4-6), 0.25 ml by mouth every hour PRN for pain (0-3); mirtazapine (medication to treat depression) 7.5 mg tablet at bedtime; oxycodone (medication to treat pain) 5 mg tablet one tablet every eight hours PRN; and Eliquis (medication to treat blood clots) 5 mg tablet two times a day for pulmonary embolism. A Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 6/27/2024 documented a start of care for Hospice services as 1/10/2024, with period of coverage for 4/9/2024 to 7/7/2024. A review of the care plan initiated 4/16/2024 for R19 revealed there is no care plan focus area addressing R19's anticoagulant use, pain, psychotropic drug use, pressure ulcer (risk of), behavioral symptoms, functional abilities, dementia, delirium or Hospice. Interview on 7/21/2024 at 5:50 pm, the MDS Coordinator confirmed the resident did not have a care plan addressing the psychotropic drug use, anticoagulant use, or that the resident was on Hospice. During further interview, she confirmed that the care plans did not carry over to the new EMR system. 4. A review of the EMR revealed that R20 was admitted to the facility on [DATE] with diagnoses including intracranial hemorrhage, hypertension (HTN), Alzheimer's disease, metabolic encephalopathy, and stage 3 chronic kidney disease. A review of the July 2024 Medication Administration Record (MAR) revealed that R20 was ordered to receive olanzapine (medication to treat schizophrenia) 2.5 mg tablet one tablet every 24 hours PRN for delirium. A review of the quarterly MDS assessment dated [DATE], revealed that R20 CAAs triggered delirium, cognitive loss/dementia, functional abilities (self-care and mobility), pressure ulcer/injury, psychotropic drug use, urinary incontinence and indwelling catheter. A review of the care plan initiated 7/2/2024 for R20 revealed there is no care plan focus area addressing R20's psychotropic drug use, functional abilities, pressure ulcer risk, urinary incontinence, or delirium. Interview on 7/21/2024 at 5:25 pm, the MDS Coordinator stated that as she completes new MDS assessments after 4/1/2024, all the are plans should be carried over into the new system. She was asked why the resident's care plans had not been carried over into the new system even after they received a comprehensive MDS assessment after 4/1/2024, and she stated that she did not know why. She confirmed that R20 did not have a care plan addressing psychotropic drug use, functional abilities, pressure ulcer risk, urinary incontinence, or delirium on the current care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/22/2024 at 10:50 am, the Assistant Director of Nursing (ADON) stated that she does not do anything with the MDS. She stated the facility did not have all the residents medical records downloaded into the new EMR system because the electronic migration has not taken place. She stated if residents had a new MDS assessment after 4/1/2024, the care plans should be in the new EMR system. Interview on 7/22/2024 at 2:29 pm, Licensed Practical Nurse (LPN) FF stated she was hired in April 2024 and confirmed that she does not have access to the old EMR system to see what the resident care plans documented for resident care. Interview on 7/22/2024 at 3:40 pm with the administrator and DON, revealed that the facility went from using one EMR system to another EMR system. The DON stated many of the resident care plans and other information are in the prior EMR system. She stated that not all of the nursing staff has access to the old EMR system or the older care plans. She stated that the previous system would only have resident information before 4/1/2024. The administrator stated the facility had a Quality Assurance Process Improvement (QAPI) plan in place before the implementation date of the new EMR. He stated it consisted of months of planning and in that planning, the facility had Process Improvement Plan (PIP) that was completed on 4/1/2024. 44960 5. Review of the clinical record revealed R12 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, type 2 diabetes, anxiety disorder and Alzheimer's Disease. A review of the quarterly MDS assessment dated [DATE] revealed that R12 had a BIMS score of 12, indicating moderate cognitive impairment. A review of the CAAs revealed R12 triggered for cognitive loss/dementia, functional abilities (self-care and mobility), and psychotropic drug use. Section I revealed a diagnosis of Alzheimer's. Review of the July 2024 MAR revealed R12 had an order for Quetiapine (a medication used to treat mental health conditions) 25 mg half tablet by mouth daily at bedtime, with a start date of 6/25/2024. A review of the care plan initiated on 5/21/2024 for R12 revealed no comprehensive plan of care developed to address R12's diagnosis of Alzheimer's dementia. Interview on 7/20/2024 at 9:32 am, the MDS Coordinator stated it was expected to have the Alzheimer/Dementia diagnosis captured in the updated care plan. The MDS confirmed she was not able to locate the care plan for R12 addressing her diagnoses of Alzheimer's/Dementia. She stated it may be in their previous EMAR system. During further interview, the ADON could not explain why the Alzheimer's/Dementia care was not captured on the updated care plan completed 5/21/2024.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37739 Based on observations, record review, and interviews, the facility failed to ensure that activities of daily living (ADL) care was provided for two of five dependent residents (R) (R5 and R15). Findings included: 1. A review of the electronic medical record (EMR) revealed that R5 was admitted to the facility on [DATE] with diagnoses including orthostatic hypotension, muscle weakness, and depression. A review of the annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) date of 7/4/2024, revealed that R5 presented with a Brief Interview for Mental Status (BIMS) score of 14, indicating that she was cognitively intact. Review of the Care Area Assessment (CAA) revealed that R5 triggered for functional abilities (self-care and mobility). Observation on 7/20/2024 at 9:14 am, revealed that R5 was pleasant and alert, with 1/4 inch length of chin hair. During an interview at this time, R5 stated that she would like to have the chin hair removed, but sometimes she does not notice it. She stated that the hairdresser assisted her with trimming the hair on her face when she had her hair done but she isn't at the facility every day. She stated that she does not want to go out with hair on her face so she would like for the staff to remind her and help her shave it. Observation on 7/21/2024 at 11:40 am, R5 was in the dining room and observed with facial hair on her chin. Observation on 7/22/2024 at 11:30 am, R5 was sitting in the dining room. She still had not been assisted with removing the facial hair from her chin. During an interview on 7/22/2024 at 1:29 pm, Certified Nursing Assistant (CNA) MM stated that she is an agency staff but she has worked at this facility multiple times. She confirmed that she assists R5 with her ADL care, but stated she did not notice that R5 had facial hair that needed to be shaved. During further interview, she stated that residents are shaved on their shower day. During an interview on 7/22/2024 at 4:09 pm, the Director of Nursing (DON) stated that residents have three baths/showers per week and the direct care staff should be performing the task of shaving the residents. She confirmed that R5's shower day was Saturday evening and that her facial hair should have been trimmed. During further interview, she stated that sometimes the hairdresser will cut the residents chin hairs, but could not comment on why it was not completed for R5. 2. A review of the EMR revealed that R15 was admitted to the facility on [DATE] with a diagnosis of dementia. A review of the quarterly MDS assessment dated [DATE] revealed that R15 presented with a BIMS of three, indicating that the resident presents with severe cognitive impairment. The CAAS indicated the resident triggered for cognitive loss/dementia, communication, and functional abilities (self-care and mobility). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/22/2024 at 11:45 am, R15 was alert with confusion. She was observed with chin whiskers. She was asked about her facial hair, and she placed her fingers on her chin and stated, Oh, my. I need to get that off. During an interview on 7/22/2024 at 11:33 am, CNA NN stated R15 is gotten up by the night shift staff. When she was asked if the resident required ADL care assistance, she confirmed that the resident did, but stated she has had not tended to the resident today. She was asked why she had not tended to the resident, and the CNA changed her statement and stated that she had checked on the resident earlier, but she did not need ADL assistance. She was asked if she checked with the resident whether she wanted her facial hair trimmed or shaved and she stated, No I didn't ask. During an interview with the DON on 7/22/2024 at 4:15 pm, the DON confirmed that R15's shower day was Friday and Monday mornings and that she should have had her facial hair shaved.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38997 Based on record review, staff interviews, review of the policy titled Pharmacy Policy & Procedure Guide for Care Centers, and review of job descriptions, the facility failed to provide pharmaceutical services that dispensed the correct dosage of physician ordered medication for one of twenty sampled residents (R) (R77). R77 was administered an incorrect dosage of lamotrigine (medication for seizures) for 13 days before a medication error was recognized. Harm was identified to have occurred on 7/15/2024 when R77 experienced a grand mal seizure due to receiving a subtherapeutic dose of lamotrigine. Findings include: Review of the policy titled Pharmacy Policy & Procedure Guide for Care Centers, with a review date of 10/5/2021, revealed the Purpose, Objective, and Goals. Purpose: Number 1. To strive to protect the safety and welfare of patients receiving medications while residing in a nursing center. These guidelines are consistent with all State and Federal laws and generally accepted principles of pharmacy and nursing practices. Objective: Number 3. To strive to promote the rational, safe and economic dispensing of medications to nursing center patients. Goal: Number 1. To strive to provide patients with the needed medications, in a timely manner (as ordered by the patient's prescriber) and in a manner consistent with high professional standards. General Guidelines for Medication Administration Intent: Medications are administered as prescribed, in accordance with good nursing principles. Procedural Guidelines: The joint responsibility of the nursing center and the pharmacy is to ensure accurate medication administration. Review of the Pharmacy Director job description, dated 7/22/2024 revealed Purpose Summary: The Director is responsible for developing, coordinating, and supervising of all pharmaceutical services of the facility. Responsibilities: Number 6. Submit a Quarterly Report of Pharmacy Services to the Executive Director and Quality Assurance Committee. Number 29. Interpret physicians' orders and dispense all pharmaceuticals incoming from the facility's pharmacy, or directly supervises this task being done by a pharmacy technician. Number 30. Other functions as necessary to insure safe and efficient use of pharmaceuticals in the facility. Review of the Director of Health Services job description dated 12/17/1998 revealed Responsibilities/Duties: Number 1. Directs, supervises and coordinates the functions and activities of the Health Services Department to include nursing, pharmacy, rehab, medical records, social services and Physician services. Number 2. Creates and maintains an atmosphere of warmth and personal interest ensuring a positive, calm environment throughout the facility. Number 3. Ensures that each resident receives the necessary nursing, medical and psychological services to attain and maintain the highest possible mental and physical functional status. Review of the Admission Record revealed R77 was admitted to the facility on [DATE] with a diagnosis of seizures. Review of the Order Summary Report dated 7/2/2024 revealed lamotrigine ER 250 mg. Give one tablet by mouth in the morning related to other seizures, with start date of 7/3/2024. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Review of R77's medication card (bubble pack) filled by the facility's pharmacist on 7/2/2024 revealed Lamotrigine 25 mg tablet. Review of a Nursing Alert Note dated 7/15/2024 at 11:00 am documented resident suddenly screamed out with her hands wide and proceeded to have what appeared to be a grand mal seizure. Her back was arched, feet turned downward, and eyes rolled upwards. She had a clenched jaw, head was extended back and exhibited difficulty in breathing due to airway issue. Seizure activity lasted approximately five to ten minutes, followed by 10 - 15-minute post-ictal {sic} state. Nurse Practitioner (NP) present during post-ictal {sic} phase and Physician arrived shortly thereafter. Interview on 7/20/2024 at 1:50 pm, the Director of Nursing (DON) stated R77 was admitted to the facility on [DATE]. She confirmed the discharge medications included lamotrigine 250 mgER on ce a day for a diagnosis of seizures. She stated the pharmacy dispensed lamotrigine 25 mg tablets, instead of the 250 mg tablets, and R77 received the lamotrigine 25 mg for 13 days, instead of the prescribed 250 mg ER. She stated the medication error was identified after the resident had a grand mal seizure on 7/15/2024. Interview on 7/21/2024 at 12:10 pm, the Director of Health Services (DHS) also known as the Administrator, stated the Pharmacy Nurse Consultant and the Pharmacist check medication carts as well as performing medication observations with the licensed nursing staff. During further interview, the DHS revealed that the Nurse Consultant and Pharmacy reports are internal audit tools used for quality assurance and that he would not provide them to the survey team, and that they are not subject to regulatory oversight. Interview on 7/22/2024 at 8:43 am, Pharmacy Director BB stated the Pharmacy Technician inputs resident medication orders and the Pharmacist fills the orders and label's the bubble pack. The medication is then checked against a delivery manifest and the medication and delivery manifest are delivered to the unit and checked again with the nurse receiving the medication. During further interview, the Pharmacy Director BB stated the incident with R77 happened because the checks and balances were not followed. She stated the previous Pharmacy Director was inputting the orders, filling the orders, and packaging the medication. A phone interview on 7/22/2024 at 10:35 am, previous Pharmacy Director AA revealed she worked approximately three weeks at the facility, through a staffing agency, until a full-time pharmacist was hired. The Pharmacy Director stated once the medication orders were received, they were entered by the pharmacy technician. The pharmacist was responsible for filling the medications and generating the delivery manifest. She stated no one from the facility called her to inform her of the medication error for R77. Interview on 7/22/2024 at 12:30 pm, Pharmacist CC reviewed the lamotrigine medication bubble pack card, and confirmed that the initials on the card were hers and the medication was filled based on what was entered by the pharmacy technician. Interview on 7/22/2024 at 3:55 pm, the Executive Director stated the facility utilizes Nurse Consultant Services for medication cart audits, resident medication audits, and medication pass observation. He stated that information is available for the survey team, and he will ensure the information is provided. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	The facility did not provide the medication cart audit, resident medication audit, or medication pass observation to the survey team. Cross refer F760

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	115775	A. Building B. Wing	07/22/2024

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38997 Based on record review, staff interviews, review of the policy titled Pharmacy Policy & Procedure Guide for Care Centers, and review of employee job descriptions, the facility failed to ensure one of 20 sampled residents (R) (R77) was free from a significant medication error related to not administering medications according to the physician orders. Specifically, R77 was ordered lamotrigine (a medication used to treat seizures) 250 milligrams (mg) extended release (ER) daily, but was only administered 25 mg per day, due to a pharmacy dispensing error. Actual harm was identified to have occurred on [DATE] when R77 suffered a grand mal seizure, as a result of a subtherapeutic dose of lamotrigine for 13 days. Findings include: Review of the policy titled Pharmacy Policy & Procedure Guide for Care Centers with a review date of [DATE] documented Purpose, Objective, and Goals. Purpose: Number 1. To strive to protect the safety and welfare of patients receiving medications while residing in a nursing center. Number 3. To strive to provide medical care team members with written guidelines, for instructional, as well as standardizing purposes, which govern all aspects of medication handling, storage, documentation, and administration. These guidelines are consistent with all State and Federal laws and generally accepted principles of pharmacy and nursing practices. Objective: Number 2. To strive to educate all concerned personnel about medications and their proper administration to patients in a nursing center. Number 3. To strive to promote the rational, safe and economic dispensing of medications to nursing center patients. Goal: Number 1. To strive to provide patients with the needed medications, in a timely manner (as ordered by the patient's prescriber) and in a manner consistent with high professional standards. General Guidelines for Medication Administration Intent: Medications are administered as prescribed, in accordance with good nursing principles. Procedural Guidelines: The joint responsibility of the nursing center and the pharmacy is to ensure accurate medication administration. The RIGHT medication must be given to the RIGHT patient in the RIGHT dose at the RIGHT time, using the RIGHT method of administration and the RIGHT method of documentation. Review of the undated Director of Nursing job description documented the Job Summary: The Director of Nursing is a registered Nurse who is responsible for the organization and implementation of nursing care in the Health Services Center. She initiates implements and evaluates nursing care to assure holistic, restorative and rehabilitative care in accordance with accepted standards. Responsibilities/Duties: Number 3. Provides direct supervision to all HSC Registered Nurse Supervisors, Nurse Managers, as well as Team Leaders, Certified Nursing Assistants and the Activity Program Coordinator on the Special Care Unit. Implements and enforces all nursing policies and procedures. Number 12. Assess residents' response to medication and make appropriate recommendations for nursing action to be implemented. Number 26. Responsible for knowledge regarding Federal, State and local nursing home rules and regulations. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the undated Staff Nurse/Team Leader job description revealed the Job Summary: The Charge Nurse is a registered nurse or a licensed practical nurse that is responsible for the organization and implementation of nursing and program care on a specified unit. She/ he initiates, implements, and evaluates nursing care to assure holistic, restorative and rehabilitative care in accordance with accepted standards. Responsibilities/Duties: Number 4. Administers medications and treatments according to established policies and procedures. Observation on [DATE] at 9:06 am, R77 was in the sitting area neatly dressed in street clothes and wearing a Thoracic Lumbar Sacral Orthosis (TLSO) and a right arm brace. Review of the Admission Record revealed R77 was admitted to the facility on [DATE] with diagnoses including seizures, displaced comminuted fracture of right radius, wedge compression fracture of fourth lumbar vertebra, and of unspecified thoracic vertebra. Review of the Medicare - 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed the assessment was in progress. Review of the care plan initiated [DATE] revealed resident is at risk for seizure activity related to diagnosis of seizure disorder. Interventions to be implemented included administer medications as ordered and implement seizure precautions per facility guidelines. Review of the hospital discharge order dated [DATE], revealed an order for lamotrigine 250 mg Tr24 (time release 24 hours) one tablet in the morning. Review of the Order Summary Report dated [DATE] revealed Lamotrigine ER 250 mg. Give one tablet by mouth in the morning related to other seizures, with start date of [DATE]. Review of the Order Summary Report dated [DATE] revealed Lamotrigine ER 250 mg Give one tablet by mouth in the morning related to other seizures, with a start date of [DATE]. Review of the Order Summary Report dated [DATE] revealed lamotrigine ER 250 mg give one tablet by mouth in the morning related to other seizures with a start date of [DATE]. Review of a photographic image of R77's medication card (bubble pack) revealed the prescription for lamotrigine 25 mg tablets was filled by the facility's pharmacy on [DATE]. Further review revealed instructions on the card were to administer per the instructions on the MAR (medication administration record). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of a Nursing Alert Note dated [DATE] at 11:00 am documented this writer was in [sic] assisting Certified Nursing Assistant (CNA) in getting resident up and readied [sic] for lunch. The resident at baseline for behavior and expression (verbal and facial). She was smiling and responding well with markedly less resistance to cares than other times. After getting resident into wheelchair, she suddenly scream out with hands wide and proceeded to have what this writer would assess, as a grand mal seizure. He [sic] back arched, feet turned downward, and eyes rolled upwards. Clenched her jaw, head was extended back and exhibited difficulty in breathing due to airway issue. This writer and a CNA placed resident on her side in bed, which alleviated enough distress to return to baseline oxygen saturation (O2 sat) and skin color pink. Seizure lasted from ,d+[DATE] mins with postictal state at ,d+[DATE] mins. Blood Pressure ,d+[DATE], pulse106, and O2 sat 95 precent room air. Nurse practitioner present during postictal time. Physician arrive to assess shortly thereafter. Pupils at 2 millimeters (mm), unreactive, returning to ,d+[DATE] mm and reactive after postictal state resolved. Interview on [DATE] at 1:50 pm, the Director of Nursing (DON) stated R77 was admitted to the facility on [DATE] from [name] Hospital. She confirmed R77's discharge medications included lamotrigine 250 mgER on ce a day for a diagnosis of seizures. During further interview, she stated the pharmacy dispensed lamotrigine 25 mg tablets, instead of the 250 mg tablets, reflecting that R77 received the lamotrigine 25 mg for 13 days, instead of the prescribed 250 mg ER. She stated the medication error was identified after the resident had a grand mal seizure on [DATE]. She stated the nursing staff has been in serviced on medication administration - five rights, and the medications must be checked before placing them on the cart. Interview on [DATE] at 7:59 am, Registered Nurse (RN) DD stated that she was working on [DATE] when R77 had the grand mal seizure. She stated after the seizure, she herself, the Physician, and the Nurse Practitioner checked the hospital discharge orders against the order put in the residents' EMR and confirmed that both orders were for lamotrigine ER 250 mg. RN DD stated she then checked the bubble pack of lamotrigine medication, which revealed the bubble pack was filled with lamotrigine 25 mg tablets. RN DD stated that residents are often times given low dosages of lamotrigine to treat behaviors, and because R77 did exhibit behaviors at times, she didn't think anything about her taking 25 mg instead of 250 mg. The RN DD confirmed that she did not follow the five rights of medication administration. During further interview, RN DD stated that she received education on medication administration and reading the MAR and the bubble pack to make sure they match. She stated discrepancies should be reported to the charge nurse before administering the medication. Interview on [DATE] at 8:40 am, the Director of Nursing (DON) revealed the policy Medication Management-Certified Medication Assistant was the only policy the facility had on medication administration. She stated she is aware that the policy references Certified Medication Aides, but stated only license nurses are allowed to pass medications to the residents. Interview on [DATE] at 8:43 am, Pharmacy Director BB stated the nursing staff should be following the policy for medication administration found in the Pharmacy Policy & Procedure Guide for Care Centers. She stated the manual should be at each nursing station. Interview on [DATE] at 9:30 am, Licensed Practical Nurse (LPN) FF stated she is aware of the incident regarding R77's medication. LPN FF stated she has not been provided any education on medication administration and stated no one in the facility has observed medication pass with her. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Interview on [DATE] at 11:30 am, LPN EE stated she is familiar with the care that R77 required. She revealed on the days she administered R77 her medications, she did not check the bubble pack with the MAR to ensure she was administering the correct dose of medication. She stated the Nurse Educator provided education on medication administration, reading the MAR, and the bubble pack to make sure everything matched.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 44960 Based on record review, review of the Certifying Board of Dietary Managers and interviews, the facility failed to ensure that the dietary department had a designated staff as director of food and nutrition services, was a certified dietary or food service manager, or had a similar food service management or degree to provide the daily functions/duties of a Dietary Manager. This deficient practice had the potential to affect 25 of 25 residents who received meals in the facility. Findings include: Review of the document titled Certifying Board of Dietary Managers dated 4/2023 revealed States Recognizing the CDM, CFPP Credential reads all 50 states must follow the CMS federal guidelines as outlined in rule $483.60 Food and Nutrition Services and have adopted state-level regulations that meet or exceed the federal standards. Review of the employee file for the Dietary Manager (DM) revealed a hire date of 1/29/2021. The DM employee file revealed no certification or education degree in culinary art or any other food service management degree. Interview on 7/22/2024 at 10:27 am, during the initial tour of the kitchen, the DM was asked to provide her certification as the DM. She stated that she did not have the certification yet, but would soon be enrolling in a course, to become certified. She stated she had been employed in her position since April 2024. She stated that the Registered Dietitian was not full-time and came to the facility on ce a week. Interview on 7/22/2024 at 3:55 pm, the Executive Director stated that he was aware the DM was not certified. He stated that the DM did not need to be certified now, according to the Certified Board for Dietary Managers. He also stated that the Director of Dining Services was working on getting his CDM, but he had not completed his coursework.