STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Living and Rehab Center	106 Cameron Street Lake Waccamaw, NC 28450

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on record review, staff, and resident interviews, the facility failed to treat a resident (Resident #50) with dignity and respect when a nurse refused to leave the resident's room upon request and when the resident was not assisted out of the shower when requested. The resident expressed feelings of anger and frustration. This was for 1 of 1 resident reviewed for dignity. Findings included: Resident #50 was admitted to the facility on [DATE]. Diagnoses included, in part, right below the knee amputation with prothesis. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed resident was cognitively intact and demonstrated no behaviors. 1a. Review of an investigation report submitted to the Department of Health and Human Services (DHHS) on 02/21/24 for an abuse allegation on 02/15/24 indicated Resident #50 reported that the nurse on night shift (Nurse #12) hit his leg three times and was verbally aggressive towards him while attempting to give him his medication. No physical or mental injury was reported. This was reported to the Police and Department of Social Services (DSS) on 02/15/24. Review of the police report dated 02/15/24 stated, Victim [Resident #50] stated that the offender [Nurse #12] struck him on the leg 3 times and then became verbally aggressive towards him. He did state that he got verbally aggressive with her after the fact. Offender stated that she shook the leg of resident to wake him up for his medications but did not strike him. No injuries were noted at time of reporting. A summary of the facility investigation dated 02/21/24 revealed Concerns were reported to the Social Worker by the resident [Resident #50]. It was determined that the allegation of physical abuse was unsubstantiated, however it was determined that the employee [Nurse #12] placed her hands on the resident [Resident #50] shaking him when asking if he would take his medications. It was determined the employee [Nurse #12] was verbally aggressive to the resident and provoked him before exiting room. Employee [Nurse #12] admitted to not leaving his room when asked and continued to provoke him. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #50 was conducted on 06/10/24 at 1:00 PM. Resident #50 stated Nurse #12 had come into his room on 02/15/24 at about 9:30 PM, had hit his leg and woke him and told him he needed to take his medications. Resident #50 told Nurse #12 to get out of his room and she hit his leg again, insisting she needed a yes or no answer if he was going to take his medications. Resident #50 stated he again told Nurse #12 to get out of his room and she hit his leg a third time and insisted again that she needed a yes or no answer if he was going to take his medications. Resident #50 stated he told her to get out and he covered his head with the bed covers. He stated he pressed the call light to get another staff member to come in and witness Nurse #12 hitting him and refusing to leave the room. He stated Nurse Aide (NA) #7 came into the room and was trying to get Nurse #12 to leave him alone, but she kept insisting on a yes or no answer. Resident #50 stated he did not give her a yes or no answer, but by him stating get out several times, Nurse #12 should have taken that as a refusal to take his medications. He stated he was very upset that Nurse #12 had woken him up to take his medications and he got increasingly angry when she was refusing to leave when he asked her to leave several times. Resident #50 stated he felt like Nurse #12 was treating him like a child. A phone interview with Nurse Aide #7 on 06/27/24 at 12:35 PM revealed on 02/15/24 she was standing at the nurse's station on the 100 hall and she had heard Nurse #12 arguing with Resident #50 and heard Resident #50 saying get out, get out, get out of my room. NA #7 stated she told NA #6 they needed to go down to his room and see what was going on. NA #7 stated she was standing at Resident #50's room and heard Resident #50 say I told you to leave my room, and Nurse #12 replied I am not going anywhere until you say yes or no. NA #7 stated Resident #50 continued to tell Nurse #12 to leave, and Nurse #12 continued to demand a yes or no answer. She stated Resident #50 had the covers over his head and she heard Nurse #12 say I am going to ask one more time and he said I told you to leave the room. NA #7 stated when she entered the room she tried to encourage Resident #50 to take his medications. She stated the refusal to leave the room as Resident #50 requested and the insistence of taking the medications went on for about 10 minutes. She stated she never saw Nurse #12 strike Resident #50. She added, Nurse #12 had a cup of water in one hand and the medication cup in another hand. NA #7 stated Resident #50 was angry and he was getting louder with Nurse #12 when she kept refusing to leave the room. NA #7 stated there was a lot of name calling between Nurse #12 and Resident #50 with each of them calling each other names such as crazy, liar and stupid. An interview with NA #6 on 06/19/25 revealed on 02/15/24 Nurse #12 went to Resident #50's room to give him his medications. She stated she could hear Nurse #12 and Resident #50 yelling at the nurse's station which was about 4 rooms away from the nursing station. She stated she could hear Resident #50 telling Nurse #12 to get out of the room and Nurse #12 saying Yes or no are you going to take your medications? NA #6 stated the back and forth arguing between Resident #50 and Nurse #12 went on for a few minutes. She and NA #7 went down to the room and she noticed Nurse #12 had a cup of water in one hand and the medication cup in the other hand. NA #6 stated she did not see Nurse #12 physically touch Resident #50, but she was refusing to leave the room when he asked her to and Resident #50 was getting angry and upset with Nurse #12 for not leaving when asked to. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted with Nurse #12 on 06/14/24 at 4:27 PM. Nurse #12 stated on 02/15/24 she was trying to give Resident #50 his medications and he told me to leave. Nurse #12 stated he did not outwardly refuse, he just kept telling her to get out of his room. Nurse #12 stated the last time Resident #50 refused his medication he accused her of not giving him his medications when he actually refused to take them. She added, she wanted a yes or no answer to accurately document that he refused the medications. Nurse #12 stated she woke him up gingerly by shaking his leg one time and she did not touch him more than once. She stated he had the sheet over his head and was telling her to get out of his room. She stated he was upset when she arrived in the room and he did not change his demeanor while she was in the room, but he was yelling at her while she persisted for a yes or no answer and calling her a liar. She stated, in looking back, she should have left the room and accepted him stating get out of my room as a refusal and documented that instead of yes or no, but she was concerned he was going to report her to management stating she did not bring in his medications. Nurse #12 denied calling Resident #50 stupid or crazy. An interview was conducted with the Administrator on 06/14/24 at 5:00 PM. The Administrator stated after she conducted the investigation it had been determined that Nurse #12 did not physically abuse Resident #50 but she did refuse to leave his room when asked several times and failed to treat the resident with dignity and respect by honoring his request. The Administrator added, she had three in services regarding dignity and respect since she started in early February 2024. The facility provided a plan of correction for this incident but it was not accepted as it did contain all the required components. 1b. Review of an incident report dated 05/17/24 revealed the resident [Resident #50] reported he asked to get a shower early because his family was visiting. Nurse Aide [NA #8] from another hall took resident to shower and then left. Resident stated he was left in shower room for 15 - 20 minutes before the same Nurse Aide [NA #8] came in and assisted him back to his wheelchair. Camera footage was reviewed and confirmed the call light sounded and was on for 15 minutes and 23 seconds before Nurse Aide [NA #8] came back to the shower to assist Resident in getting back into his wheelchair. Review of the camera footage time line on an incident report dated 05/17/24 revealed the following: 10:42 AM Resident #50 entered the shower room and NA #8 followed Resident #50 and entered the shower room 10:46 AM Nurse Aide #8 exited the shower room 10:48 AM Nurse Aide #8 reentered the shower room 10:49 AM Nurse Aide #8 exited the shower room 11:00 AM Call light in shower room sounds 11:16 AM Nurse Aide #8 entered the shower room 11:20 AM Nurse Aide #8 and Resident #50 exited shower room and went to Nurse #9 and were telling her something (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #50 on 06/14/24 at 1:00 PM revealed on 05/17/24, he was left unattended in the shower for over 15 minutes. He stated prior to the shower he was on the smoking porch and stated he wanted to get a shower early on this day because he had family coming. Resident #50 stated Nurse Aide (NA) #8 said he was not on her assignment, but that she would get him started in the shower. He used the call bell to alert for help when he was done. He stated no one came after a few minutes so he turned the water again to keep himself warm and washed himself again while waiting for someone to answer the call bell. He stated he then started to yell for someone to come and help him, but no one came. Resident #50 stated the shower chair did not have wheels like his wheelchair so he was not able to move it easily, but he was able to reach a towel and dry off and reached his prosthetic leg and put it on. He stated he continued to yell, but still no one came. Resident #50 stated he then attempted to transfer himself from the shower chair to the wheelchair but he banged his leg and was not able to transfer himself safely. Resident #50 stated after about 15 minutes, NA #8 finally came back and helped him get out of the shower chair and transferred him to his wheelchair. Resident #50 stated he was very angry and frustrated that he was left unattended and had wait so long to get assistance. An interview was conducted with NA #8 on 06/14/24 at 2:35 PM. NA #8 reported on 05/17/24 she was on the smoking porch with Resident #50 and he reported he wanted a shower. He stated his aides from the 100 hall were busy so she told him she would get him in the shower. NA #8 stated she was assigned to the 200 hall, but she helped transfer Resident #50 to a shower chair from his wheelchair and assisted with removing his clothes and his prosthetic leg. She then turned on the water and he began to take his shower. NA #8 stated that she and Nurse #7 who was assigned to the 200 hall told Nurse #9 who was assigned to the 100 hall that they were going to the store to get soap which was located across the street and only minutes away. NA #8 stated they were back within 15 minutes or less and when they came back, they saw the shower light going off and Nurse #9 was sitting at the computer at the nurse's station. She stated she went into the shower room and saw Resident #50 was still in the shower. She assisted him with getting dressed and brought him out of the shower room. She stated Resident #50 was very angry and wanted to know why his aides left him in the shower room. An interview was conducted with Nurse #7 on 06/13/24 at 11:45 AM. Nurse #7 reported on 05/17/24, Resident #50 was out on the smoking porch and stated he had family coming in to see him today and he wanted a shower and NA #8 said she would give him one. NA #8 assisted Resident #50 in the shower. She stated after he was in the shower, she and NA #8 told Nurse #9 that we were leaving the facility to go to the store across the street to get soap and that Resident #50 was in the shower and for her to let his aides know so they could get him out. Nurse #7 reported they were at store for about 15 minutes and when they came back, the call light was on to the shower room. Nurse #7 stated NA #8 went to the shower room to assist Resident #50 out of the shower. Nurse #7 reported when Resident #50 came out of the shower room, he was very upset because no one came to answer his light and assist him. An interview was conducted with Nurse #9 via phone on 06/13/24 at 2:19 PM. Nurse #9 reported she was the nurse assigned to the 100 hall on 05/17/24 where Resident #50 resided. She stated she was sitting at the nurse's station on 05/17/24 when Resident #50 came to the desk and asked where his aides were. She stated Resident #50 was very upset and frustrated about being left in the shower room and that no one was answering the call light to assist him. She stated Resident #50 told her that NA #8 had put him in the shower and left. Nurse #9 stated she had learned from NA #8 that she and Nurse #7 left the building to go to the store, but it was not until they returned. Nurse #9 stated neither NA #8 nor Nurse #7 reported to her that Resident #50 was in the shower or that they were going to the store. Nurse #9 stated she did not recall hearing the call light going off. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with NA #4 via phone on 06/18/24 at 10:39 AM. NA #4 reported she had worked at the facility as agency nurse aide for about 8 weeks. She stated she was assigned to Resident #50 on the 100 hall on 05/17/24. NA #4 reported she did not know what had actually happened on 05/17/24 but was told someone put Resident #50 in the shower, but they did not inform her or NA #5 who was also assigned to Resident #50. NA #4 reported Resident #50 and Nurse #9 approached her and NA #5 while they were doing resident care for another resident and Resident #50 was yelling at them for leaving him in the shower, but they had no idea he was even in the shower. An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 11:00 AM. The DON reported that a nursing staff member should always be with a resident whenever they were getting a shower. The DON stated she did not know NA #8 and Nurse #7 left the building on 05/17/24 and it was not okay for them to leave without telling anyone. She stated her expectation of nursing staff was that the call bell in shower room should have been responded to when it was sounding. She stated Resident #50 needed assistance with getting dressed and having to wait in a shower room for 15 minutes unassisted and undressed was too long.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, and staff, resident, and Physician interviews, the facility failed to notify the physician that the scheduled medication gabapentin, a medication ordered for nerve pain that is not to be stopped abruptly, was not administered. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24 and had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms and the physician was not notified of this. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The physician was not notified that Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, the facility failed to notify the physician that 14 doses of the antibiotic Amoxicillin 875 mg was administered to Resident #39 instead of the antibiotic Augmentin (Amoxicillin-Clavulanate 875 mg-125 mg) that was ordered by the physician on discharge from the hospital. This deficient practice affected 3 of 10 residents reviewed for notification. Immediate Jeopardy began for Resident #51 on 5/9/24 when the resident reported a pain scale of 10, had not been receiving gabapentin, and the physician was not notified, and on 5/12/24 for Resident #46 when the resident had increased pain, difficulty sleeping, had not been receiving gabapentin, and the physician was notified. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Example #3 was cited at scope and severity D. Findings included: 1. Resident #51 was admitted on [DATE] with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities). Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. The May 2024 Medication Administration Record (MAR) indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. This MAR and the medication administration notes revealed Resident #51's gabapentin was not administered on 5/8/24 at 5:00 PM and 9:00 PM and on 5/9/24, 5/10/24, 5/11/24, 5/12/24 and 5/13/24 at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. A pain assessment dated [DATE] was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse #9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse #9 stated Resident #51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse #9 indicated Resident #51 refused her shower on 5/9/24 which was not normal for her, reporting she was in too much pain. Nurse #9 stated she was not aware that she should have notified the physician of Resident #51's increased pain and the ordered medication gabapentin that was not administered. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 indicated she did not notify the physician that Resident #51 had not received the scheduled gabapentin. Nurse #8 stated she did not realize that she should have notified the physician that the medication was not available and not administered as ordered. Nurse #8 stated she did not report Resident #51's increased pain to the physician. A nursing progress note by Nurse #13 on 5/10/24 at 3:24 AM stated Resident #51 reported her legs were numb. The note stated the nurse informed Resident #51 there were no interventions for that and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room . Attempts were made to interview Nurse #13 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not notify the physician that the medication gabapentin was not available and not administered and had increased pain. Unit Manager #1 was unable to explain why she did not notify the physician that the ordered medication gabapentin was not administered to Resident #51. A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to emergency room . Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal. An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated due to acute pain and received gabapentin. The discharge instructions were to take prescription medications as ordered including gabapentin 800 mg 4 times per day and to not stop taking prescription medication for pain suddenly. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM and was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider of the resident's change in condition and requested to be sent to the hospital. Resident #51 was sent to the hospital per her request. Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. Nurse #14 worked at the facility through an agency. A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening muscle spasms all over and requested to go to the emergency department. 911 was called for transfer to the emergency room . Resident #51 returned to the facility having received Gabapentin at the emergency room . Resident #51 told the emergency room staff that until she received her Gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. emergency room physician sent a new prescription for Gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM. An ED Summary dated 5/13/24 indicated Resident #51 was evaluated due to acute pain. Resident #51 received gabapentin in the emergency room and the emergency room physician sent a new prescription for gabapentin to the pharmacy. An in-person interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for Resident #51 and why the physician was not notified. The DON stated she expected the nurses to notify the physician when medications were not available for administration. An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications would be available and administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identify that a medication was not available for administration. An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated she was in the position at the facility since 6/7/24. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered and if the ordered medication was not obtained the physician should be notified. Attempts were made via phone to interview the previous physician with messages left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received. 2. Resident #46 was admitted on [DATE] with diagnosis which included diabetes and neuropathy. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain. Resident #46's May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM. The MAR revealed on 5/10/24 at 9:00 PM, and on 5/11/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24, 5/16/24 and 5/17/24 at 9:00 AM and 9:00 PM, the nursing staff documented the gabapentin was not administered. An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin the medication was not administered due to it being unavailable. Nurse #3 stated she did not notify the physician that she had not administered the prescribed medication gabapentin and was unaware that she should have done this. An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that worked at the facility for several months. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart and she did not notify the physician that the gabapentin was not administered. Nurse #6 stated she was not aware that she was supposed to notify the physician. An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse #17 indicated she was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24 from 7:00 PM to 7:00 AM. Nurse #17 stated she did not notify the physician that she did not administer the scheduled gabapentin on 5/13/24, 5/14/24 and 5/15/24. Nurse #17 did not have an explanation why she did not notify the physician. An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 recalled gabapentin was not available on the medication cart, but she did not notify the physician. Nurse #7 stated Resident #46 was upset and had increased pain when she did not receive the ordered gabapentin. Nurse #7 was unable to explain why she had not notified the physician of Resident #46's medication gabapentin not administered and resident's increased pain. An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered, resident had increased pain and she did not notify the physician. An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM. Nurse #5 stated she did not notify the physician the medication was unavailable or of the missed doses. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the prescribed dose for Resident #46 on 5/17/24 and she did not notify the physician. Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM. Messages were left on 6/11/24 and 6/12/24 with no return call received. An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated she had gone without gabapentin for days at a time on several occasions. Resident #46 reported staff stated the medication was coming from the pharmacy and then it didn't come in. Resident indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not receive her gabapentin. Resident #46 stated it was horrible and the staff told her she would just have to wait it out until the medication came in. Resident #46 stated she was not aware if the physician was notified of her medication not being administered as ordered. An in-person interview with the Director of Nursing (DON) on 6/12/24 at 4:15 PM revealed the nurses on the medication cart were expected to notify the physician when a medication was not available and administered as ordered. The DON stated she started at the facility at the end of March 2024. The DON stated she was not aware the physician was not notified. The DON expected the nurses to notify the physician of changes in condition including uncontrolled pain, medications not administered, and residents transferred to the hospital for evaluation. An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected the physician to be notified when medications were not available and administered as ordered. The Administrator stated nursing staff did not understand what to do when they identified a medication was not available for administration and this included notification of the physician for further orders. An interview was conducted by phone with the Physician on 6/18/24 at 1:20 PM. The Physician stated she had been in the position since 6/7/24. The Physician indicated the dose of gabapentin ordered, 800 mg twice per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the risk of withdrawal and increased pain. Withdrawal symptoms can occur within 12 hours and can be severe. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered. She stated it was the responsibility of the facility to notify the physician when a scheduled medication was not available. Attempts were made via phone to interview the previous physician with messages left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received. The Administrator was notified of Immediate Jeopardy on 6/13/24 at 2:15 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to notify the provider when two residents (Resident #51 and Resident #46) were not administered their ordered gabapentin for multiple doses. Resident #51 was not administered her routine order for gabapentin 800 mg 4 times a day from 05/08/2024 - 05/13/2024. A licensed nurse stated she did not notify the physician when the medication was not available. The nurse stated that if medication was not available for a few days, then she would call the pharmacy. The facility Unit Manager #1 was aware of the gabapentin not being available but did not recall what happened or what she did about obtaining the medication. The documentation in the electronic health record (EHR) showed no evidence that the physician was notified. On 05/09/2024 Resident #51 refused a shower due to too much pain. On 05/10/2024 Resident #51 complained of her legs feeling numb. On 05/12/2024 Resident #51 complained of pain and spasming in which Resident #51 requested to go to the emergency room (ER). Resident #51 returned from the ER where the resident was treated for acute pain and received gabapentin at the hospital. In the evening on 05/12/2024 Resident #51 complained of agitation and anxiety due to not receiving gabapentin and requested to go to the ER. Resident #51 received gabapentin in the ER. The physician in the ER sent a new prescription for gabapentin to the pharmacy. Resident #46 was not administered her routine order for gabapentin 800 mg 2 times a day from 05/10/2024 - 05/17/2024. Unit Manager #2 stated there had been delays in receiving refills of gabapentin and resident had been without the ordered gabapentin. She stated she did not notify the physician. Resident #46 had a pain level of 8 or 9 constantly during the time the facility failed to obtain and administer the medication. Resident #46 complained of not receiving pain medication which caused her more pain and made it hard to sleep. Resident #46 complained of irritability, being anxious, and nausea. Resident #46 had not felt well and had not been able to get out of bed to participate in activities and perform a daily routine due to pain in her legs. Residents with missed medications, changes in conditions, and residents who have had a documented risk management report are at a greater risk of the physician not being notified. Therefore, effective 06/13/2024, the Administrator, Director of Nursing, and Unit Managers (UMs) completed an audit for the past 90 days of all residents in the facility who had missed medications, changes in conditions, and/or a documented risk management report to ensure the physician had been notified. On 06/15/2024 it was determined by this audit that the physician had not been notified of every missed medication, change in condition, and documented risk management report. The concerns were identified and reported to the physician to ensure the notification of change. A documented risk management report is a report that a nurse completes to document resident incidents such as medication errors, falls, skin tears, pressure ulcers, etc. Any resident incident that occurs in the facility is documented in the electronic health record. It includes general details of the incident, a description of the incident, any statements from the resident or witnesses and any follow-up action to be taken by the nursing staff. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 06/13/2024 the Director of Nursing educated Floor Nurses and Unit Managers (UMs) on the process to notify the physician when there are missed medications, changes in conditions, and/or a resident who has a documented risk management report. Nurses will notify the physician immediately via phone call to the on-call service provider that is posted at each nursing station. This process will happen if the nurse is working in the facility and witnesses a missed medication, change in condition, and/or if the nurse completes a documented risk management report on any resident. The Director of Nursing and Unit Managers (UMs) will begin in person education on 06/13/2024 with all nurses and medication aides which will include all full-time, part-time, as needed, and agency staff. This education will be on the importance of notifying the physician of any missed medications, changes in conditions, and documented risk management reports. No nurses or medication aides will work after 06/13/2024 until they have received the above noted education. The Director of Nursing will be responsible for keeping up with those nurses and medication aides who have and have not been educated. The Director of Nursing is responsible for completing the education or assigning the UM to complete the education for any staff who has not been educated by 06/13/2024. The UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure staff notify the provider when there are missed medications, changes in conditions, and/or if a resident has a documented risk management report. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator. On 06/14/2024 the Director of Nursing and provider reviewed the facility provider communication log. Effective 06/13/2024 the Director of Nursing will provide education to ensure all nurses and medication aides (full-time, part-time, as needed, and agency) have comprehensive knowledge of how to utilize the provider communication log. The provider communication log is located in a white binder at each nursing station in the facility. The Floor Nurses and UMs will utilize this provider communication log daily to document any reason for why the provider should see a resident such as for a sick visit, readmission, new admission, orders to be signed, at the resident's request, at the resident's families request, medication refills, changes in conditions, and/or documented risk management reports. Effective as of 06/13/2024 Floor Nurses and UMs will be responsible for ensuring this provider communication log is updated daily. The Floor Nurses and UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure staff notify the provider when there are missed medications, changes in conditions, and/or a resident who has a documented risk management report. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator. All newly hired nurses and medication aides, (full-time, part-time, as needed, and agency) will be educated as noted above. This will be completed by the Director of Nursing. The Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Director of Nursing is responsible for completing the education with new hires. The Director of Nursing was notified of this responsibility on 06/13/2024 by the Administrator. Alleged date of immediate jeopardy removal: 6/16/24 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The removal plan of the Immediate Jeopardy was validated on 06/19/24. The audit conducted for all residents who had missed medications, changes in conditions, and/or a documented risk management report to ensure the physician had been notified was verified and confirmed any identified concerns were reported to the physician. A sample of staff including the Administrator, Unit Manager, nurses and medication aides were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding the process of notifying the physician when there are missed medications or changes in condition. The IJ removal date of 06/16/24 was validated. 37673 3. Resident #39 was admitted to the facility on [DATE] with a diagnosis of a urinary tract infection (UTI). The hospital discharge summary dated 05/02/24 revealed the following physician order: Amoxicillin-Clavulanate 875 mg-125 mg tablet oral every 12 hours for 7 days, (Augmentin). Amoxicillin-Clavulanate is a combination penicillin-type antibiotic used to treat a wide variety of bacterial infections. The facility MAR (Medication Administration Record) for May 2024 revealed Resident #39 was administered Amoxicillin 875 mg-give 1 tablet by mouth every 12 hours for a UTI x 7 days. He received the Amoxicillin 875 mg on the following dates for a total of 14 doses: 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/07/24, 05/08/24, 05/09/24, and 05/10/24. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had intact cognition. He had an indwelling urinary catheter. He had undergone recent genitourinary surgery (refers to the urinary organs of the body) that required skilled nursing care. He was administered antibiotic medication. Review of the Consultant Pharmacist ' s Medication Regimen Review dated 05/27/24 revealed the following recommendation: This resident was admitted with an order for Amoxicillin/Clavulanate 875 MG BID (twice a day) for 7 days. This was entered into the computer as Amoxicillin 875 MG. This is what the pharmacy sent. Please notify the provider of the medication error to clarify if any additional treatment is needed. Please review with the nurses to ensure they read orders carefully and double check entries. In an interview with the Consultant Pharmacist on 6/12/24 at 9:50 AM she stated the difference between Amoxicillin and Amoxicillin-Clavulanate was that the Clavulanate drug helped the Amoxicillin work better and more types of bacteria were affected by the addition of Clavulanate. She would have expected the provider to be notified to report the medication error and determine if additional treatment was necessary. In an interview with the Director of Nursing (DON) on 06/12/24 at 4:40 PM she stated she had not followed up on the pharmacy recommendation and had not notified the provider that the wrong antibiotic had been administered to Resident #39 to determine if further treatment was necessary. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the facility physician on 06/19/24 at 9:30 AM she stated she had not been notified that Resident #39 was given the wrong antibiotic. She noted she started at the facility last week and was not his doctor when this occurred. However, she reported she had seen Resident #39 yesterday and he was not having any symptoms of a UTI at this time. She did not feel any further intervention was required. She stated she would expect to be notified whenever there was a pharmacy recommendation or a medication error so that it could be addressed when it occurred.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and interviews with resident, staff, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, Psychiatrist, Physician, and Wound Clinic Physician, the facility failed to protect the residents' right to be free of neglect when the facility failed to obtain significant medications (Resident #51, Resident #46, and Resident #8), administer significant medications (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8), notify the physician that scheduled medication for nerve pain that was not to be stopped abruptly was not administered (Resident #51 and Resident #46), and provide effective pain management (Resident #51 and Resident #46). Resident #269 was administered 6 doses of haloperidol (antipsychotic medication) 20 milligrams (mg) instead of the ordered dosage of 2 tablets of 2 mg at bedtime and was not administered carvedilol (a medication used to treat heart failure, high blood pressure and chest pain) for 25 of the ordered doses. Resident #269 experienced an elevated pulse and shortness of breath requiring Emergency Department (ED) evaluation on 3/14/24. Resident #51's scheduled gabapentin was not obtained and administered for 21 doses resulting in ineffective pain management as evidenced by complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. The physician was not notified. Resident #51 was transferred to the ED twice on 5/12/24 where she was treated for acute pain with gabapentin and returned to the facility. Resident #46's scheduled gabapentin was not obtained and administered for 14 doses resulting in ineffective pain management as evidenced by increased pain, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. The physician was not notified. Resident #419 was not administered 6 doses of intravenous (IV) (delivered into the vein) Rocephin (antibiotic) and 7 doses of IV Daptomycin (antibiotic) for treatment of his infected stage 4 sacral (triangular bone at the base of the spine) pressure ulcer. The resident was hospitalized and the discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection). This deficient practice affected 9 of 10 residents reviewed for neglect. Immediate Jeopardy began on 3/14/24 when the facility neglected to administer Resident #269's haloperidol and carvedilol as ordered and the resident required ED evaluation due to shortness of breath and an elevated pulse. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Residents #8, #10, #32, #39, and #50 were cited at scope and severity E. The findings included: This tag is cross referenced to: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F580: Based on record review, and staff, resident, and Physician interviews, the facility failed to notify the physician that the scheduled medication gabapentin, a medication ordered for nerve pain that is not to be stopped abruptly, was not administered. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24 and had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms and the physician was not notified of this. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The physician was not notified that Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, the facility failed to notify the physician that 14 doses of the antibiotic Amoxicillin 875 mg was administered to Resident #39 instead of the antibiotic Augmentin (Amoxicillin-Clavulanate 875 mg-125 mg) that was ordered by the physician on discharge from the hospital. This deficient practice affected 3 of 10 residents reviewed for notification. F697: Based on record review, staff, resident, Consultant Pharmacist, and Physician interview, the facility failed to provide effective pain management and manage symptoms of withdraw for 2 of 10 residents (Resident #51 and Resident #46) reviewed for pain management. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not available to administer and resulted in a total of 21 doses of the prescribed medication not administered from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain at up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) per her request on 5/12/24 in the middle of the night where she was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED that evening per her request for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not available to administer on 5/10/24 and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in increased pain at a sustained 8-9 pain level, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F755: Based on record review, staff, resident, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, and Physician interview, the facility failed to ensure scheduled medication was obtained and available for administration for 3 of 10 residents (Resident #51, Resident #46, and Resident #8) reviewed for medications. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) on 5/12/24 in the middle of the night after missing 14 doses of the medication. She was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED that evening for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, Resident #8 was prescribed Oxycodone/Acetaminophen (opioid medication) 10/325 mg and this medication was not obtained from the pharmacy resulting in multiple missed doses of the medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F760: Based on record review and interviews with resident, staff, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, Physician, and Wound Clinic Physician, the facility failed to prevent significant medication errors for 9 of 10 residents reviewed (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8). Resident #269 was administered 6 doses of haloperidol (antipsychotic medication) 20 milligrams (mg) instead of the ordered dosage of 2 tablets of 2 mg at bedtime and was not administered carvedilol (a medication used to treat heart failure, high blood pressure and chest pain) for 25 of the ordered doses. Resident #269 experienced an elevated pulse and shortness of breath requiring Emergency Department (ED) evaluation on 3/14/24. Resident #51 was not administered 21 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/8/24 through 5/13/24 resulting in complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the ED twice on 5/12/24 where she was treated for acute pain with gabapentin and returned to the facility. Resident #46 was not administered 14 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/10/24 through 5/17/24 resulting in increased pain, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Resident #419 was not administered 6 doses of intravenous (IV) (delivered into the vein) Rocephin (antibiotic) and 7 doses of IV Daptomycin (antibiotic) for treatment of his infected stage 4 sacral (triangular bone at the base of the spine) pressure ulcer. The resident was hospitalized on [DATE] and the 4/26/24 discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection). In addition, the facility: administered 14 doses of Amoxicillin (antibiotic) to Resident #39 instead of the ordered Amoxicillin-Clavulanate; did not administer 34 doses of Resident #32's ordered mirtazapine (antidepressant medication); did not administer 23 doses of Resident #10's ordered tetrabenazine prescribed for the treatment of tardive dyskinesia (involuntary movements such as tongue thrusting, rapid eye blinking, repetitive chewing, that can occur with long term psychotropic use); did not follow the parameters indicated in the physician's order for Resident #50's blood pressure medication resulting in 8 doses not administered as ordered; and did not administer 12 doses of Resident #8's Oxycodone/Acetaminophen (opioid pain medication), 3 doses of Ozempic (anti-diabetic medication), 1 dose of Glipizide (anti-diabetic medication), and 1 dose of Rivaroxaban (anticoagulant). An interview was conducted via phone with the Physician on 6/18/24 at 1:20 pm. The Physician indicated it was the facility's responsibility to provide the services necessary for the residents. An interview was conducted in person with the Director of Nursing (DON) on 6/14/24 at 4:10 PM. The DON indicated that staff not providing services needed to the resident was a form of neglect. She indicated education was provided to nursing staff to educate them on providing services the residents required. The Administrator was notified of immediate jeopardy on 6/13/24 at 5:00 PM. The facility provided the following immediate jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The facility failed to protect Residents #46, #51, #269, and #419 from neglect as evidenced by the following deficient practices: (continued on next page)

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	345185	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Living and Rehab Center	106 Cameron Street Lake Waccamaw, NC 28450

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	580: The facility failed to notify the physician when two residents (Resident #51 and #46) were not administered their ordered gabapentin for multiple doses. 697: The facility failed to effectively manage Resident #51's and Resident #46's pain. 755: The facility failed to ensure routine pain medication was obtained and available for administration for Resident #51 and Resident #46. 760: The facility failed to prevent significant medication errors for Resident #269, Resident #419, Resident #51, and Resident #46. The facility became aware of this neglect allegation for Resident #51 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The facility became aware of this neglect allegation for Resident #46 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The facility became aware of this neglect allegation for Resident #269 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The facility became aware of this neglect allegation for Resident #419 on 06/13/2024. The neglect allegation was reported to the Health Care Personal Registry on 06/14/2024 and has been reported to law enforcement and Adult Protective Services on 06/16/2024. The Administrator and Director of Nursing identified that all current residents have the potential to be affected by this deficient practice. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete: On 06/13/2024 the Administrator, Director of Nursing, Social Worker, and Unit Managers (UMs) began educating all staff on the facility abuse and neglect policy. This education will be on the importance of staff understanding that all residents have a right to be free of neglect and that failing to provide the necessary care and services to residents constitutes neglect. All staff will have a comprehensive understanding that the following are necessary care and services: obtaining and administering medications as ordered by provider, effectively managing pain, and notifying the physician of significant changes to include any issues with administering significant medications as ordered. The Administrator, Director of Nursing, Social Worker, and Unit Managers (UMs) will begin in person education on 06/13/2024 with all staff which will include all full-time, part-time, as needed, contract staffing departments, and agency staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No staff member will work after 06/13/2024 until they have received the education. The Social Worker and Director of Nursing will be responsible for keeping up with staff who have and have not been educated. The Social Worker, the Director of Nursing, and UMs are responsible for completing the education with all staff including any staff who have not been educated by 06/13/2024. The UMs were notified of their responsibility on 06/13/2024 by the Director of Nursing. The Social Worker and the Director of Nursing will be responsible for tracking the education and ensuring it is completed so that the facility has an effective system in place to ensure the facility implements effective systems so that residents receive the necessary care and services that are needed. The Social Worker and the Director of Nursing were notified of this responsibility on 06/13/2024 by the Administrator. All newly hired staff (full-time, part-time, as needed, contract staffing departments and agency) will be educated as noted above. This will be completed by the Social Worker, Human Resources Coordinator, and/or Director of Nursing. The Social Worker, Human Resources Coordinator, and the Director of Nursing will be responsible for keeping up with new hires who have and have not been educated. The Social Worker, Human Resources Coordinator, and the Director of Nursing are responsible for completing the education with new hires. The Social Worker, Human Resources Coordinator, and the Director of Nursing were notified of this responsibility on 06/13/2024 by the Administrator. Alleged date of immediate jeopardy removal: 6/16/24 The removal plan of the Immediate Jeopardy was validated on 06/19/24. A sample of staff including the Administrator, Unit Manager, nurses and medication aides were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they had been in-serviced regarding the importance of staff understanding that all residents have a right to be free of neglect and understood that failing to provide the necessary care and services to residents constitutes neglect such as obtaining and administering medications as ordered, managing pain, and notifying the physician of significant changes. The IJ removal date of 6/16/24 was validated.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35173 Based on record review and staff interviews, the facility failed to submit a report of an allegation of neglect to Adult Protective Services (APS) and law enforcement within the required time frame for 4 of 4 residents (Resident #46, #51, #269 and #419) reviewed for neglect. The facility was officially notified of neglect on 06/13/24 at 2:15 PM when an immediate jeopardy template was issued. The facility did not notify APS or law enforcement within the required time frame following notification. Findings included: Review of the facility provided initial allegation report dated 06/14/24 regarding Residents #46, #51, #269, and #419 revealed no documentation of APS being notified and no record of law enforcement notification. During an annual recertification survey and complaint investigation, the facility was officially notified of neglect on 06/13/24 at 2:15 PM and an immediate jeopardy template was issued to the Administrator. The immediate jeopardy template was signed by the Administrator and the Administrator was verbally informed of the information regarding the situation involving neglect. Review of the state agency records revealed the facility submitted an initial report to the State Agency within the required time frame following the notification of neglect, however documentation supported that the facility did not notify law enforcement or APS until 06/16/24. During a phone interview with the facility Administrator on 06/17/24 at 4:30 PM, she stated she submitted an initial allegation report to the State Agency regarding the neglect information provided on the template which she had received on 06/13/24. She stated since the neglect was identified by the state surveying staff and she received a template for the immediate jeopardy she was confused as to whether or not she would still have to notify APS and law enforcement. She stated it was not until she was reviewing the template and the initial allegation report on 06/16/24 when she realized she should notify law enforcement and APS and on 06/16/24 she notified both.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and staff interviews, the facility failed to complete the comprehensive Minimum Data Set (MDS) assessments within the required timeframe for 5 of 29 residents reviewed for MDS assessments (Resident #269, Resident #17, Resident #9, Resident #24 and Resident #16). Findings included: a. Resident #269 was admitted on [DATE]. Resident #269's admission Minimum Data Set (MDS) dated [DATE] was completed on 5/15/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner. b. Resident #17 was admitted on [DATE]. Resident #17's annual Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/12/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner. c. Resident #9 was admitted on [DATE]. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9's annual Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/12/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner. d. Resident #24 was admitted on [DATE]. Resident #24's annual Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/12/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training since she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was looking for a solution. An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner. e. Resident #16 was readmitted on [DATE]. Resident #16's admission Minimum Data Set (MDS) assessment dated [DATE] was completed on 5/27/24. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she had been in training shince she started in May taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed the assessments. MDS Nurse #2 stated she was told the MDS assessments were beind. An interview with the Administrator on 6/14/24 at 4:41 PM revealed there had been personnel changes in the role of MDS Nurse several times since she started in February. The Administrator stated she was aware MDS assessments were not completed within the regulatory timeframe, and she was lokking for a solution. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 6/14/24 at 4:10 PM revealed she was aware that the MDS assessments were not completed in a timely manner due to staffing changes. The DON stated the expectation was that MDS assessments would be completed in a timely manner.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and staff interviews, the facility failed to complete quarterly assessments within the required 14-day timeframe for 14 of 29 residents reviewed for quarterly MDS assessments. (Resident #20, Resident #36, Resident #51, Resident #22, Resident #38, Resident #61, Resident #63, Resident #5, Resident #21, Resident #47, Resident #7, Resident #14, Resident #26, and Resident #58). Findings included: a. Resident #20 was admitted on [DATE]. Resident #20's quarterly Minimum Data Set (MDS) assessment dated [DATE] was listed as in progress and was incomplete. b. Resident #36 was admitted to the facility on [DATE]. Resident #36's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/11/24. c. Resident #51 was admitted on [DATE]. Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/4/24. d. Resident #22 was admitted on [DATE]. Resident #22's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 5/30/24. e. Resident #38 was admitted on [DATE]. Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/11/24. f. Resident #61 was admitted on [DATE]. Resident #61's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/11/24. g. Resident #63 was admitted on [DATE]. Resident #63's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/13/24. h. Resident #5 was admitted on [DATE]. Resident #5's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/11/24. i. Resident #21 was admitted on [DATE]. Resident #21's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/4/24. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. Resident #47 was admitted on [DATE]. Resident #47's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/13/24. k. Resident #7 was admitted on [DATE]. Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/5/24. l. Resident #14 was admitted on [DATE]. Resident #14's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/13/24. m. Resident #26 was admitted on [DATE]. Resident #26's quarterly Minimum Data Set (MDS) assessment dated [DATE] was completed on 6/11/24. n. Resident #58 was admitted on [DATE]. Resident #58's quarterly Minimum Data Set (MDS) dated [DATE] was listed as in progress and was not completed. An interview was conducted on 06/17/24 at 1:37 PM with the Remote MDS Nurse. She stated she was aware that MDS assessments were not completed within the state designated time frame. The Remote MDS Nurse stated she was contracted on 04/30/24 to complete MDS assessments and the facility was behind on assessments when she started. An interview was conducted with MDS Nurse #2 on 6/11/24 at 1:57 PM. MDS Nurse #2 stated she started in May and was training taking online MDS courses to learn the requirements for the assessments. MDS Nurse #2 stated since she was still learning it was the Remote MDS Nurse that completed assessments since she started. MDS Nurse #2 stated she was told the MDS assessments were behind. An interview was conducted with the Administrator on 6/11/24 at 1:42 PM. The Administrator stated she had been in the position since February of this year. The Administrator stated there had been changes in the role of MDS Nurse several times since she started. The Administrator stated due to the changes in personnel, the MDS assessments were behind and were not completed in a timely manner. An interview with the Director of Nursing on 6/14/24 at 4:10 PM revealed there was a problem with the MDS Assessments not being completed in a timely manner due to staffing changes.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on record review and staff interviews the facility failed to transmit the quarterly Minimum Data Set within the required time frame for 1 of 26 resident assessments reviewed (Resident #5). Findings included: Resident #5 was admitted into the facility on [DATE]. Resident #5's medical record revealed his quarterly Minimum Data Set, dated dated dated [DATE] was signed as completed on 04/15/24 with a transmission date of 06/11/24. An interview was conducted on 06/17/24 at 1:37 PM with the Minimum Data Set Coordinator. She stated she was aware that the quarterly Minimum Data Set for Resident #5 had not been transmitted within the designated time frame. She stated she knew Resident #5's MDS was transmitted late. An interview was conducted on 06/14/24 at 11:15 AM with the Administrator. She indicated that all Minimum Data Sets should be transmitted in a timely manner as required.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 26 residents reviewed (Resident #50, Resident #61, and Resident #8). Findings included: 1. Resident #50 was admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease, and diabetic foot ulcer. Review of pharmacy consultant notes written on 01/22/24 and 02/15/24 revealed the resident had a diagnosis of diabetic foot infection and chronic inflammatory polyneuropathy. The Minimum Data Set (MDS) quarterly assessment dated [DATE] did not have Resident #50 coded as having a venous or arterial ulcer or as having a diabetic foot ulcer. Review of the care plan dated 03/08/24 revealed Resident #50 had a plan of care for diabetes mellitus with interventions to include inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness; and a plan of care for potential pressure area related to decreased mobility and peripheral vascular disease with interventions to include monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs or symptoms of infection to physician and weekly treatment documentation to include measurement of each area of skin breakdown, width, length, depth, type of tissue and exudate and other notable changes or observations. A review of the physician's order written on 10/23/23 revealed an order to cleanse left heel topically with a topical medication every Monday, Wednesday and Friday for wound healing. This was discontinued on 05/10/24. A phone interview was conducted with the remote MDS nurse on 06/18/24 at 12:59 PM revealed she was a contract employee and had been at the facility since April 30, 2024. She stated she worked remotely and she had access to the electronic medical records so she could complete the assessments based on the documentation in the look back period. She stated she reviewed physician orders, diagnoses, nursing progress notes and nursing assessments in order to accurately code the MDS. She added, she did not do any actual face to face assessments. She stated she was able to retrieve the information about the resident by reviewing the documentation. The remote MDS nurse reviewed Resident #50's medical record at this time and confirmed that he was admitted with a diabetic foot ulcer and was receiving treatments for this wound since admission. The remote MDS nurse stated she should have coded him as having a diabetic foot ulcer. A phone interview was conducted on 06/19/24 at 4:00 PM with the Administrator. The Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for accurately coding the MDS assessments. 41387 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #61 was admitted on [DATE] to the facility. Diagnoses included a condition in which the immune system attacks the nerves and pain. A review of the physician's orders recorded an order for Methadone HCL (a long acting opioid medication) 5 milligrams (mg) two tablets twice a day for pain was written on 2/1/2024 for Resident #61. The April 2024 Medication Administration Record (MAR) recorded Resident #61 was receiving Methadone HCL twice a day. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #61 was cognitively intact and was not receiving opioids (pain relieving medications). Resident #61's care plan dated 6/11/2024 included a focus for pain. Interventions included administering analgesics (medications that relieve pain) per physician orders and to evaluate the effectiveness in relieving pain. The June 2024 MAR recorded Resident #61 continued to receive Methadone HCL 5 mg twice a day. On 6/19/2024 at 11:19 a.m. in a phone interview with the Remote MDS Nurse for the facility, she explained based on her notes from reviewing Resident #61's electronic medical record (EMR) when completing the MDS assessment, Resident #61 was not on any opioids. After the Remote MDS Nurse reviewed Resident #61's EMR, she stated Resident #61 was receiving Methadone, an opioid, daily when the quarterly assessment dated [DATE] was completed. She said she missed coding Resident #61's MDS assessment for opioid. She explained it was an oversight or a stroke of the computer key error. On 6/19/2024 at 10:22 a.m. in a phone interview with the Director of Nursing (DON), she explained due to the inconsistency of having a MDS nurse in the facility, the facility was using a Remote MDS nurse to complete MDS assessments. She explained the Remote MDS Nurse used information in the EMR that could lead to inadequate MDS assessment of Resident #61 use of opioids. The DON stated she had not conducted any monitoring related to the accuracy of completed MDS assessments by the Remote MDS Nurse. On 6/19/2024 at 12:25 p.m in a phone interview with the Administrator, she stated the DON oversaw MDS assessments to ensure completed correctly, and Resident #61's MDS assessment should had included the use of opioids. 49502 3. Resident #8 was admitted to the facility on [DATE] with diagnoses which included chronic atrial fibrillation. Review of Resident #8's Physician Orders revealed an order for Rivaroxaban (a blood thinner) 5 mg every day for chronic atrial fibrillation written on 8/19/23. Resident #8's Medication Administration Record 8/19/23 was reviewed and indicated she received Rivaroxaban 5 mg by mouth daily since she was admitted to the facility on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was not coded as receiving anticoagulants on a scheduled or routine basis. During an interview with the MDS nurse on 6/17/24 at 10:08 am she further indicated she was completing MDS assessments remotely. She also indicated it could have been not coded for anticoagulant use in error. In an interview with the Administrator on 6/17/24 at 11:07 am she indicated the MDS should be coded and processed accurately.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to develop an individualized person-centered baseline care plan within forty-eight hours of admission for 2 of 26 residents reviewed for care planning (Resident #16 and Resident #319). Findings included: 1. a. Resident #16 was admitted to the facility on [DATE] with diagnoses including stroke. The physician's orders dated 4/26/2024 included an order for rivaroxaban (an anticoagulant medication that prevents or break down blood clots) 20 milligrams(mg) via gastrostomy tube (G-Tube) in the evening for anticoagulation. Resident #16's April 2024 Medication Administration Record (MAR) recorded rivaroxaban 20 milligrams (mg) was administered 4/27/2024, 4/28/2024 and 4/29/2024. There was no individualized person-centered baseline care plan located in Resident #16's medical record for the 4/26/2024 admission. Nursing documentation dated 4/29/2024 at 8:25 p.m. reported Resident #16 was coughing up blood and bleeding profusely from the nose. Emergency Medical Services (EMS) was called to transport Resident #16 to the hospital. b. Resident #16 was readmitted to the facility on [DATE]. The 5-day admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was severely impaired cognitively and was not coded for receiving anticoagulants. Resident #16's May 2024 Medication Administration Record (MAR) recorded rivaroxaban 20 milligrams (mg) was restarted on 5/9/2024 and administered every evening from 5/9/2024 to 5/31/2024 except for 5/29/2024. Resident #16's June 2024 MAR recorded rivaroxaban 20 mg was administered every evening from June 1, 2024, to June 13, 2024 except on 6/5/2024 and 6/9/2024 when Resident #16 was out of the facility. There was no individualized person-centered baseline care plan located in Resident #16's medical record for the 5/9/2024 admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/2024 at 11:19 a.m. in a phone interview with the Remote MDS Nurse for the facility, she explained she was hired by the facility to work remotely and to complete MDS assessments. She stated the nursing staff at the facility were responsible for completing individualized person-centered baseline care plans for residents and the individualized person-centered baseline care plan was active until the MDS Nurse completed the comprehensive care plan. She stated Resident #16 was receiving anticoagulants on admission, and an individualized person-centered baseline care plan should have been completed within the first forty-eight hours of admission. On 6/19/2024 at 10:22 p.m. during a phone interview with the Director of Nursing (DON), she stated the MDS Nurse located at the facility was responsible for completing the individualized person-centered baseline care plans. The DON explained there had not been a consistent MDS Nurse at the facility since before March 2024. She stated there was only one MDS Nurse, and individualized person-centered baseline care plans were not being completed because the MDS Nurse was working on completing the back log of MDS assessments. The DON stated Resident #16 should have had an individualized person-centered baseline care plan started within two hours of admission to the facility. On 6/19/2024 at 12:25 p.m. during a phone interview with the Administrator, she explained although the MDS Nurse at the facility was the responsible person to complete the individualized person-centered baseline care plan after admission, licensed nurses could start an individualized person-centered baseline care plan. She further explained the administration team decided since March 2024 to transition the licensed nursing staff to start resident's individualized person-centered baseline care plans and was just realizing the transition had not occurred. 49502 2. Resident #319 was admitted to the facility on [DATE] with diagnoses which included type 2 Diabetes Mellitus, aphasia, and a recent history of a cerebral vascular accident (stroke) with hemiplegia (loss of strength or almost complete weakness on one side of the body). A review of Resident #319's Electronic Medical Record (EMR) revealed no baseline care plan. Review of Resident #319's admission Minimum Data Set (MDS) revealed admission assessment completed on 5/1/24. During an interview with the Remote MDS nurse on 6/17/24 at 10:08 am she revealed that assessments were completed late because the previous nurse could not get caught up. She further indicated she was completing MDS assessments remotely. During a phone interview with the Director of Nursing (DON) on 6/18/24 at 11:14 am she stated the MDS nurse was responsible for developing the baseline care plan within 48 hours. She further stated she did not know why this was not completed upon Resident #319's admission. In a phone interview with the Administrator on 6/18/24 at 9:03 am she stated Resident #319's admission MDS assessment should have been completed within the regulatory time frame.

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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** 40044 Based on record review, and staff interviews the facility failed to develop and implement a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include: the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration (Resident #11), at risk for nutritional status (Resident #219 and Resident #34), assistance with activities of daily living, nutrition, and urinary incontinence (Resident #52); and for not developing a comprehensive care plan for a resident receiving anticoagulant medication (blood thinner) (Resident #16). This was for 5 of 26 residents reviewed. Finding included: 1. Resident #11 was admitted to the facility on [DATE] with diagnoses including in part; dementia, hearing loss, and cerebral vascular accident (CVA). The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #11 had moderately impaired cognition. He had moderate difficulty hearing, and difficulty communicating some words or thoughts. He had impaired vision and used corrective lenses. He had no falls and was at risk for falls. No pressure ulcers and at risk of pressure ulcers. He had broken teeth and received pain medication. He required assistance with activities of daily living. The care area assessment dated [DATE] indicated to initiate care plans in the following areas: psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration. Review of Resident #11's electronic medical record from admission on 08/11/23 through 06/19/24 revealed no care plan in place for Resident #11 to address psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, or dehydration. During a phone interview on 06/19/24 at 2:05 PM the MDS nurse stated she worked for an agency that was contracted with the facility and completed MDS assessments and care plans remotely. She began working for the facility on 04/30/24. She indicated although she was not the person that was responsible for creating the initial comprehensive care plan for Resident #11, the care plans should have been completed from the care areas that triggered on the MDS admission assessment. She reviewed the MDS and care plan for Resident #11 and agreed a care plan should have been implemented in the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, or dehydration. During an interview on 06/14/24 at 4:00 PM the Director of Nursing (DON) stated she was not aware that care plans were not implemented for Resident #11. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 06/19/24 at 4:00 PM the Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and care plans should have been initiated for Resident #11. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible. 2. Resident #219 was admitted to the facility on [DATE] with diagnosis including cellulitis of the left lower limb and diabetes. The MDS admission assessment dated [DATE] revealed Resident #219 was cognitively intact. She received wound care and a therapeutic diet. The care area assessment dated [DATE] indicated to initiate a care plan that included nutritional status. Review of Resident #219's electronic medical record from admission on 05/22/24 through 06/19/24 revealed no care plan in place for Resident #219 to address Nutritional status with measurable goals and interventions. During a phone interview on 06/19/24 at 2:05 PM the MDS nurse stated she was responsible for initiating the comprehensive care plan for Resident #219. She reported that she missed initiating the care plan as indicated on the MDS admission assessment in the area of nutrition. She stated it was done in error. During an interview on 06/14/24 at 4:00 PM the Director of Nursing (DON) stated she was not aware that care plans were not implemented for Resident #219. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines. During a phone interview on 06/19/24 at 4:00 PM the Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and care plans should have been initiated for Resident #219. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible. 35173 3. Resident #52 was admitted to the facility on [DATE]. Diagnoses included, in part, dementia, seizures, syncope and chronic kidney disease. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #52 was severely cognitively impaired and required assistance with activities of daily living and was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #52's weight was recorded as 193 pounds and there were no nutritional approaches indicated. The care area assessment dated [DATE] indicated to initiate care plans in the following areas: activities of daily living, urinary incontinence, and nutritional status. Review of Resident #52's electronic medical record from admission on 05/02/24 through 06/19/24 revealed there were no care plans in place to address nutritional status, activities of daily living, or urinary incontinence. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 06/14/24 at 4:00 PM with the Director of Nursing (DON). The DON stated she was not aware that care plans were not implemented for Resident #52. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines. A phone interview was conducted on 06/19/24 at 2:05 PM with the MDS nurse. The MDS nurse stated she worked for an agency that was contracted with the facility and completed MDS assessments and care plans remotely. She began working for the facility on 04/30/24. She indicated although she was not the person that was responsible for creating the initial comprehensive care plan for Resident #52, the care plans should have been completed from the care areas that triggered on the MDS admission assessment. She reviewed the MDS and care plan for Resident #52 and agreed a care plan should have been implemented in the areas of nutritional status, activities of daily living and urinary incontinence. A phone interview was conducted on 06/19/24 at 4:00 PM with the Administrator. The Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and care plans should have been initiated for Resident #52. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible. 4. Resident #34 was admitted to the facility on [DATE]. Diagnoses included, in part, cancer, anxiety and depression, acquired absence of kidney, and dementia. The MDS admission assessment dated [DATE] revealed Resident #34 was moderately cognitively impaired; weight was recorded as 155 pounds and he was on a mechanically altered diet. The MDS quarterly assessment dated [DATE] revealed Resident #34 was moderately cognitively impaired. Resident #34 was coded as coughing or choking during meals or when swallowing medications and weight was recorded as 139 pounds. Resident #34 had a weight loss of 5% or more in the last month or a loss of 10% or more in last 6 months and was on a mechanically altered diet. Review of Resident #34's electronic medical record from admission on 02/01/24 through 06/19/24 revealed there was no care plan in place to address nutritional status. An interview was conducted with the DON on 06/14/24 at 4:00 PM. The Director of Nursing (DON) stated she was not aware that the nutritional care plan was not implemented for Resident #34. She stated there had been staff turnover with the MDS nurses. She indicated care plans should be developed and implemented according to the required CMS (Centers for Medicare & Medicaid) guidelines. A phone interview was conducted on 06/19/24 at 2:05 PM with the MDS nurse. The MDS nurse stated she worked for an agency that was contracted with the facility and completed MDS assessments and care plans remotely. She began working for the facility on 04/30/24. She indicated although she was not the person that was responsible for creating the initial comprehensive care plan for Resident #34, the care plans should have been completed from the care area that triggered on the MDS admission assessment. She reviewed the MDS and care plan for Resident #34 and agreed a care plan should have been implemented for nutritional status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted on 06/19/24 at 4:00 PM with the Administrator. The Administrator stated there had been staff turnover with the MDS nurses. She reported the MDS nurse was responsible for developing care plans and the care plan should have been initiated for Resident #34. She reported they currently utilized an agency MDS nurse who worked remotely, and she planned to get an MDS nurse back in the facility as soon as possible. 41387 5. Resident #16 was admitted to the facility on [DATE] with diagnoses including stroke. Physician's orders dated 4/26/2024 included an order for Xarelto (an anticoagulant medication that prevents or break down blood clots) 20 milligrams (mg) via gastrostomy tube (G-Tube) in the evening for anticoagulation. Resident #16's April 2024 Medication Administration Record (MAR) recorded Xarelto 20 mg was administered 4/27/2024, 4/28/2024 and 4/29/2024. Nursing documentation dated 4/29/2024 at 8:25pm reported Resident #16 was coughing up blood and bleeding profusely from the nose. Emergency Medical Services (EMS) was called to transport Resident #16 to the hospital. Resident #16 was discharged to the hospital on 4/29/2024 and was readmitted to the facility on [DATE]. The 5-day admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was severely impaired cognitively. The Resident #16's MDS was not coded for receiving anticoagulants. Resident #16's comprehensive care plan dated 5/15/2024 did not include a focus for the use of anticoagulants. Resident #16's MAR from 5/9/2024 through 6/13/2024 revealed Resident #16 received Xarelto 20 mg as ordered. On 6/19/2024 at 11:19 am in a phone interview with the Remote MDS Nurse, she explained she was responsible for completing the comprehensive care plans after completing the MDS assessment. She stated based on the physician's order and documentation of administration of the Xarelto daily, the use of anticoagulants should have been included on the comprehensive care plan for Resident #16. She said it was an oversight on her part. On 6/19/2024 at 10:22 am in a phone interview with the Director of Nursing (DON), she explained the Remote MDS nurse or MDS Nurse at the facility was responsible for updating Resident #16's comprehensive care plan to include the use of anticoagulants and stated Resident #16 should have been care planned for the use of anticoagulants. The DON explained due to resignations of previous MDS nurses since March 2024 and a back log of MDS assessments to complete, the MDS nurses were unable to dedicate sufficient time in developing a comprehensive care plan for Resident #16. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/2024 at 12:25 pm in a phone interview with the Administrator, she stated the Director of Nursing was responsible to ensure the MDS nurses completed Resident #16's comprehensive care plan to included anticoagulants.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, resident interviews, resident representative interviews, and staff interviews, the facility failed to ensure the resident and/or the responsible party was involved in the care planning process (Resident #61 and Resident #16), to revise a resident's care plan with new fall interventions (Resident #47), and to develop a care plan within 7 days after completion of the comprehensive assessment (Resident #319). This deficient practice affected 4 of 26 residents reviewed for care planning. Findings included: 1. a. Resident #61 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #61 was cognitively intact. There was no documentation of the facility having a care plan meeting with Resident #61 or Resident #61's Representative in Resident #61's medical record. On 6/10/2024 at 2:00pm in an interview with Resident #61, he stated since his admission to the facility he had not had a care plan meeting with the different disciplines involved in his care to discuss a plan of care to prepare him for a discharge to the community. On 6/14/2024 at 11:23 am in an interview with the Social Worker, she explained she and the former MDS Nurse in the facility provided dates each month to the receptionist to schedule initial care plan meetings after residents were admitted to the facility. She stated she could not recall having a care plan meeting with Resident #61 and did not know why Resident #61's initial admission care plan meeting was not conducted in January 2024. She explained the facility did not have a process established indicating who was responsible for resident care plan meetings and stated not having a MDS Nurse located in the facility served as a barrier in communicating when care plan meetings were to be conducted. She said Resident #61's quarterly care plan meeting had not occurred because care plan meetings were not being conducted at the facility due to not having a consistent MDS Nurse. On 6/14/2024 at 3:14 pm in an interview with the Director of Nursing, she said she could not recall attending a care plan meeting for Resident #61 and was unable to locate documentation in Resident #61's medical record that a care plan meeting was conducted. b. Resident #16 was admitted to the facility on [DATE], discharged from the facility on 4/29/2024 to the hospital, and readmitted on [DATE] to the facility. The 5-day admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was severely cognitively impaired. There was no documentation of a care plan meeting with Resident #16's Representative in Resident #16's medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/2024 at 3:33 pm in a phone interview with Resident #16's Representative, she said the facility had not conducted a care plan meeting to discuss a plan of care with Resident #16's Representatives. She reported that Resident #16 was not able to communicate his needs. On 6/14/2024 at 11:23 am in an interview with the Social Worker, she explained she and the former MDS Nurse in the facility provided dates each month to the receptionist to schedule initial care plan meetings after residents were admitted to the facility. She stated she could not recall having a care plan meeting with Resident #16 or Resident #16's Representatives. She explained the facility did not have a process established indicating who was responsible for resident care plan meetings and stated not having a MDS Nurse located in the facility served as a barrier in communicating when care plan meetings were to be conducted. She said Resident #16's initial admission care plan meeting had not occurred because care plan meetings were not being conducted at the facility due to not having a consistent MDS Nurse. On 6/14/2024 at 3:14 pm in an interview with the Director of Nursing, she said she could not recall attending a care plan meeting for Resident #16 or with Resident #16's Representative and was unable to locate documentation in Resident #16's medical record that a care plan meeting was conducted to develop a individualized plan of care for Resident #16. On 6/13/2024 at 5:55 pm in an interview with the Social Worker, Director of Nursing (DON) and Administrator present, the Social Worker stated care plan meetings were recorded in the resident's medical record by herself (Social Worker) or the MDS Nurse, and the Remote MDS Nurse was not at the facility to conduct care plan meetings. The DON stated due to the MDS Nurse working remotely, care plan meetings were not held. The Administrator stated the DON was responsible for ensuring care plan meeting were conducted as scheduled. In a follow-up interview conducted with the DON by phone on 6/19/2024 at 10:22 am, she explained since March 2024 when she started at the facility, there had not been a MDS Nurse in the facility consistently to coordinate care plan meetings with the Social Worker. On 6/19/2024 at 12:25 pm in a phone interview with the Administrator, she explained the MDS coordinator was responsible for coordinating, scheduling and communicating to the interdisciplinary team members, residents and resident representatives when care plan meetings were to be conducted for residents. She stated when she started at the facility in February 2024, there was not a clear process for conducting care plan meetings. She reported she had been busy searching for staff to fill the MDS vacant position since she had not been able to find a permanent MDS Nurse. She said the Director of Nursing was responsible for the MDS department and ensuring care plan meetings were conducted to discussed with residents and/or residents' representatives the development and implementation of an individualized person centered residents' care plans. 2. Resident #47 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 was cognitively intact, required assistance from a sitting to a standing position and independently could walk up to fifty feet and self-propel a manual wheelchair. A review of Resident #47's fall incident reports dated 4/16/2024 and 5/29/2024 indicated the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/16/2024 the resident sustained a fall and a new intervention was implemented to request for Programs of All-Inclusive Care for the Elderly (PACE) to perform a medication review. - On 5/29/2024 the resident sustained a fall and a new intervention was implemented to remind resident not to stand from the wheelchair alone without two-person assist. On 6/11/2024, the quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/3/2024 was recorded as still in process. Resident #47's care plan dated 12/14/2021 and last reviewed on 6/11/2024 indicated Resident #47 had a history of falling and was at risk for falling that could result in an injury due to impaired mobility and use of psychotropic medications (medications that affect the brain chemicals involved in mental health disorders). Interventions included keeping the bed in lowest position, keeping the call bell within reach and encouraging Resident #47 to use the call bell to request assistance to get out of the bed. The goals for falls included free of injury and free of falls until next review date. The interventions indicated on the incident reports for the 4/16/2024 and 5/29/2024 falls were not included on this care plan that was last reviewed on 6/11/2024. On 6/13/2024, the new interventions from the 4/16/1024 and 5/29/2024 falls were added to Resident #47's care plan. On 6/19/2024 at 11:19 am in a phone interview with Remote MDS Nurse, she stated she updated or completed comprehensive care plans after the MDS assessment was completed, and Resident #47's comprehensive care plan for falls was updated on 6/13/2024 after the quarterly assessment with an ARD date of 5/3/2024 was completed and sent for processing. She explained Resident #47's comprehensive care plan was a live documentation tool and nursing staff at the facility was responsible for updating Resident #47's care plan to record falls and new interventions. The Remote MDS Nurse stated she didn't see where Resident #47's care plan had been updated and based on the documentation in Resident #47's electronic medical record, she had updated the care plan for falls on 6/13/2024. On 6/19/2024 at 10:22 am in a phone interview with the Director of Nursing (DON), she stated the MDS Nurse in the facility attended a risk meeting held after the clinical morning meetings to discuss falls, and the MDS Nurse was responsible for updating Resident #47's care plan after a fall was reported and new interventions implemented. She said the MDS Nurse and herself (the DON) updated resident care plans. She explained that due to the inconsistency of a MDS Nurse in the facility and with the back log MDS assessments that needed completed, the MDS Nurse had not been able to make revisions in Resident #47's care plan. She stated she had not updated Resident #47's care plan with the new interventions on 4/16/2024 and 5/29/2024 and did not provide a reason for not updating the care plan. She also stated she had not communicated with the Remote MDS Nurse to make revisions to Resident #47's fall care plan On 6/19/2024 at 12:25 pm in a phone interview with the Administrator, she stated the Director of Nursing and the MDS nurse were responsible for developing and updating Resident #47's care plan to prevent falls. She explained the MDS Nurse assigned to work in the facility was learning the MDS process and working on the back log of MDS assessments that needed to be completed and she thought the DON was transitioning the staff nurses to help with the development and revision of resident care plans, but the transition had not occurred. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49502 3. Resident #319 was admitted to the facility on [DATE] with diagnoses which included type 2 Diabetes Mellitus, aphasia, and a recent history of a cerebral vascular accident (stroke) with hemiplegia (loss of strength or almost complete weakness on one side of the body). Review of Resident #319's admission Minimum Data Set (MDS) revealed the admission assessment completed on 5/1/24. A review of Resident #319's electronic medical record (EMR) revealed no care plan was intiated until 6/13/24. During an interview with the Remote MDS nurse on 6/17/24 at 10:08 am she revealed that assessments were completed late because the previous nurse could not get caught up. She further indicated she was completing MDS assessments remotely. During a phone interview with the Director of Nursing (DON) on 6/18/24 at11:14 am she stated the MDS nurse was responsible for developing the care plans. She further stated she did not know why this was not completed for Resident #319. In an interview with the Administrator on 6/17/24 at 11:07 am she indicated the care plans should be completed within the regulatory timeframe.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on observations, record review, and resident, staff, and Wound Care Physician's interviews the facility failed to 1) perform daily wound care treatments to a non-pressure diabetic foot ulcer and implement a hind off-loading boot (a specific boot to reduce pressure on a specific part of the foot to allow a wound to heal) according to the Wound Care Physicians' orders for 1 of 3 residents (Resident #50) observed for wound care; and 2) follow physician orders to change an intravenous (IV) site every 3 days and to provide an intervention to establish IV access for a resident ordered to receive long term antibiotic therapy for 1 of 1 resident reviewed for IV medication administration (Resident #419). Findings included: 1. Resident #50 was admitted to the facility on [DATE]. Diagnoses included right below the knee amputation, peripheral vascular disease, left leg cellulitis, and diabetic foot ulcer. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed resident was cognitively intact and demonstrated no behaviors. Resident #50's was not coded as having a pressure ulcer, venous and arterial ulcer or as having a diabetic foot ulcer. Review of the care plan updated on 05/09/24 revealed Resident #50 had a plan of care for diabetes mellitus with interventions to include, in part, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, and a plan of care for potential pressure area related to decreased mobility and peripheral vascular disease with interventions ton include monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs or symptoms of infection to physician and weekly treatment documentation to include measurement of each area of skin breakdown, width, length, depth, type of tissue and exudate and other notable changes or observations. Review of the wound treatment assessments revealed the following measurements and wound orders for the diabetic wound of the left heel for Resident #50: On 04/30/24 the measurements to the left heel were recorded as 2.0 X 2.0 X 0.2 centimeters (cm) with indication the wound was improving. The treatment was silva sorb gel (antimicrobial agent), and xeroform (a pad applied to a wound to promote healing and protect the wound from harm) and wrap with kerlix. . On 05/07/24 the measurements to the left heel were recorded as 2.6 X 2.6 X 0.2 (cm) with indication that the wound was unchanged. The treatment was to apply Medi honey (helps prevent bacteria from growing), silver alginate (antimicrobial) and cover with gauze daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 05/20/24 revealed the measurements to the left heel were recorded as 2.8 X 2.8 X 0.3 (cm) with 40% slough and 60 % granulation tissue (healthy tissue) with a surface area of 7.84 (cm). The note indicated the wound was surgically debrided at this time and as a result of the procedure the wound bed decreased from 40 percent to 10 percent. The recommendations were to order a hind off-loading boot and apply Santyl (helps remove dead skin tissue and aides in wound healing) with xeroform and cover with gauze daily. A review of the physician's orders written on 05/21/24 revealed to cleanse wound with normal saline, apply Santyl with xeroform and secure with gauze daily. There was no order for a hind off-loading boot to the left heel wound. Review of the Treatment Administration Record for May 2024 revealed on 05/25/24, the wound treatment order was not signed off as evidenced by nursing initials or a check mark. Additionally, there was no order on the Treatment Administration Record for a hind off-loading boot to left heel wound. Record review revealed there was no documentation to support the dressing to the left heel wound was changed on Saturday 05/25/24. Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 05/27/24 revealed the measurements to the left heel were recorded was 3.0 x 2.2 X 0.1 (cm) with 100 % granulation tissue (healthy tissue) with a surface area of 6.60 (cm). The note indicated the wound was improving as evidenced by decreased surface area. A recommendation for a hind off-loading boot was indicated. An interview was conducted with Unit Manager (UM) #1 on 06/14/24 at 1:17 PM. UM # 1 revealed she was assigned to the hall Resident #50 resided on 05/25/24. She stated if a there was nothing charted in the treatment administration record on 05/25/24 then it meant that the treatment was not done. UM #1 reported she was not aware of an order for a hind off-loading boot for Resident #50. Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 06/03/24 revealed the measurements to the left heel were recorded as 3.6 X 2.8 X 0.1 (cm) with indication the wound was unchanged. The treatment was changed to cleanse left heel with normal saline, apply calcium alginate and Medi honey and wrap with gauze daily. The note indicated the wound was surgically debrided at this time and as a result of the procedure the wound bed decreased from 20 percent to 0. The recommendation was to order a hind off-loading boot. A review of the physician orders dated 06/03/24 revealed an order to cleanse left heel with normal saline, apply calcium alginate and Medi honey and wrap with gauze daily. Review of the Treatment Administration Record for June 2024 revealed on 06/09/24 the wound treatment order was not signed off as evidenced by nursing initials or a check mark. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and observation was conducted with Resident #50 on 06/10/24 at 1:00 PM. Resident #50 reported he was never given an off loading boot and when he inquired about it to the Director of Nursing she stated she did not know how to order the boot. Resident #50 also reported that in May, during the holiday weekend, his dressing to his left heel did not get changed. At this time, Resident #50 revealed the dressing to his left heel and added, the nurse had not changed the dressing since 06/08/24. The wound dressing was dated 06/08/24. Observation of the wound dressing to the left heel on Resident #50 with the Wound Treatment Nurse was conducted on 06/12/24 at 2:30 PM. The wound was not measured at this time. There were no signs or symptoms of infection such as odor or drainage. Resident #50 had no complaints of pain. An interview was conducted with the Wound Treatment Nurse on 06/12/24 at 2:30 PM. The Wound Treatment Nurse stated the wound to Resident #50's left heel was debrided by the Wound Care Physician on 06/03/24 and the treatment was changed. She stated whenever a wound was debrided, the wound may appear that it was worsening with increased measurement size which was due to the debridement opening up the wound bed. An interview was conducted with Unit Manager #2 on 06/14/24 at 2:00 PM. UM #2 reported she was assigned to Resident #50 on 06/09/24 and she should have changed the dressing as ordered to his left heel. She stated she was the nurse overseeing the medication aide and it was her responsible to do wound care since the medications aides were not allowed to perform wound care. Unit Manager #2 reported she was not aware of an order for a hind off loading boot for his left heel. A phone interview was conducted with the previous Wound Care Physician on 06/17/24 at 1:00 PM revealed he was familiar with Resident #50 and his chronic heel wound. He stated he would have to refer back to his records but he stated based on what he could recall he felt that the wound was chronic and it was the same or slightly better but not getting worse. The Wound Care Physician was not able to complete the interview and stated he would return the call after he reviewed the medical record. A follow up phone interview was conducted with the Wound Treatment Nurse on 06/17/24 at 2:11 PM. The Wound Treatment Nurse reported that when the Wound Care Physicians put in recommendations, they were considered orders and she would enter the orders into the electronic medical record. The Wound Treatment Nurse stated she was aware that Resident #50 had an order for the hind off-loading boot, but she was not sure why it was not ordered. The Wound Treatment Nurse stated the physician had classified the left heel wound as a diabetic ulcer since he was admitted to the facility and was acquired from his uncontrolled diabetes and peripheral vascular disease. The Wound Treatment Nurse added, she recalled letting the Director of Nursing (DON) know about the recommendation for the hind off-loading boot, but she did not follow up with the Director of Nursing to see what the status of the hind off-loading boot was or when it was going to be ordered. An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 5:00 PM. The DON revealed she would expect wound treatments to be getting according to the physician's order to prevent infection or further debilitating a declining wound. The DON stated she did not know what a hind off-loading boot was and was working on trying to figure out where to order this type of boot with local wound supply companies. A follow up call was placed to the previous Wound Care Physician on 06/18/24 at 1:57 PM. A message was left for a returned call. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 06/20/24 revealed the measurements to the left heel were recorded as 2.6 X 2.1 X 0.1cm with a surface area of 5.46 cm. Granulation tissue was noted to be at 100% with a note indicating the wound was healing as evidenced by a 45.8% decrease in surface area and 100% decrease in nonviable tissue within the wound bed and a recommendation was noted for a hind off-loading hind boot for left heel. A phone interview was conducted with the Nursing Supervisor on 06/26/24 at 11:00 AM. The Nursing Supervisor stated she was made aware from the Wound Treatment Nurse about 2 weeks ago that a hind off loading boot was needed for Resident #50. She stated she and the previous DON were trying to figure out what type of boot this was by researching on line with local wound supply companies because they had never heard of it. She stated she spoke to the current Wound Care Physician on 06/25/24 to clarify the order for the hind off-loading boot and this physician sent her a link as to what the boot was and where to order it. She stated the current DON who started on 06/19/24 will be ordering the boot. An interview with the current Director of Nursing via phone on 06/26/24 at 3:10 PM revealed she had started on 06/19/24 and it was brought to her attention on 06/25/24 from the Nursing Supervisor that Resident #50 needed the hind off-loading boot. The DON stated it should have been ordered by the previous DON. She added, she ordered the hind off-loading boot today and it will be in the facility on 06/28/24. A phone interview with the current Wound Care Physician on 06/27/24 at 9:30 AM revealed she had been attending the facility since 06/14/24 and she did mention to the Wound Treatment Nurse that the hind off loading boot should be ordered for Resident #50. She stated it was not a unique type of boot or difficult to find and she could not speak to as to why it took so long for the boot get ordered. The Wound Care Physician stated she sent a link to the Nursing Supervisor of where to purchase the boot. She added, not having the boot would not contribute to the wound worsening, it was ordered as a protective device. She stated despite the resident not having the boot for the past month, his wound was healing but it should be ordered and utilized to add that extra protection. Additionally, the Wound Care Physician stated Resident #50's wound dressing was ordered daily and she would expect the dressing to get changed daily for continued wound healing. 37673 2. Resident #419 was admitted to the facility most recently on 08/07/23. Diagnoses included, in part, a sacral stage 4 pressure ulcer, and hemiplegia and hemiparesis following a stroke (cerebral infarction) affecting his dominant right side. Review of a quarterly Minimum Data Set (MDS) assessment date 02/09/24 revealed Resident #419 had severely impaired cognition. Both upper and lower extremities on one side were impaired. He had one stage 4 pressure ulcer and one deep tissue injury that were not present on admission. He had received pressure ulcer care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for Resident #419 revised on 03/05/24 documented a focus area of antibiotic therapy. The goal was for the resident to be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions included administering antibiotic medication as ordered by the physician and to monitor and document any side effects, the effectiveness, and any signs of secondary infection related to the antibiotic therapy. 2a. The March 2024 Medication Administration Record (MAR) revealed the following physician order: Change IV (intravenous) site every day shift every 3 day(s) for infection control-Start date 03/01/24; End date 03/23/24. The MAR was coded 5 on 03/04/24 (indicating the IV site change was held) and was left blank on 03/10/24. Review of the progress notes dated 03/04/24 revealed Agency Nurse #6 documented the IV site change was to be held and that another nurse would change the IV site the following day. In an interview with Agency Nurse #6 on 06/26/24 at 12:10 PM she stated she was told on 03/04/24 not to change Resident #419's IV site because a Registered Nurse would be at the facility the next day and she would change the IV site. She could not remember who told her to hold the IV site change and did not know if the site had been changed the next day. Review of the progress notes and MAR for 03/05/24 revealed no documentation that the IV site for Resident #419 had been changed. In an interview with Nurse #5 on 06/26/24 she stated she was familiar with Resident #419 but could not remember taking care of him on 03/10/24 or changing his IV site on that date. She stated that she was not normally on his assignment, and it was too long ago to recall. 2b. Resident #419 had physician orders dated 2/23/24 for IV antibiotic daily for 4 weeks. A progress note written by Agency Nurse #2 on 3/15/24 at 3:38 pm documented Resident #419's IV had infiltrated (came out of the vein and leaked fluid into the surrounding tissue) and she was not able to give the 1:00 pm dose of antibiotic. She made two unsuccessful attempts to restart the IV. A progress note written by Nurse #13 on 03/16/24 at 12:28 am documented she attempted one time to place an IV in Resident #419's left forearm and was unsuccessful. Progress notes written by Medication Aide #5 on 03/16/24 at 11:24 am and 12:14 pm documented Resident #419 did not receive his antibiotic medications because he did not have an IV. A progress note written by Agency Nurse #2 on 03/17/24 at 4:36 pm documented an IV site was acquired and the antibiotics restarted. The MAR for 03/17/24 indicated Resident #419's antibiotics were not documented with a check mark that would have indicated the medications had been administered. A progress note written by Agency Nurse #3 on 03/20/24 at 6:49 pm documented Resident #419 ' s IV had not been working since the beginning of the shift. She attempted to restart the IV three times and the charge nurse tried to restart the IV two times, but all 5 attempts were unsuccessful. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Nurse #3 on 6/12/24 at 1:55 PM she stated while she was working the IV site stopped working and she tried to restart the IV but could not. She commented that Resident #419 was a hard stick (meaning it was difficult to start his IV). Another agency nurse on duty tried and could not get the IV started. She passed on in report to the next nurse the unsuccessful attempts to restart the IV. She noted the nursing supervisor on duty also tried to start the IV and could not. She did not know the names of the other two nurses but thought they were also from an agency. She cared for Resident #419 on 03/19/24 and 03/20/24. A progress note written by Agency Nurse #2 on 03/22/24 at 3:51 pm documented she had tried to start an IV for Resident #419, but the attempt was unsuccessful. In an interview with Agency Nurse #2 on 6/12/24 at 1:50 PM she stated she was not sure if she had tried to restart his IV access or not. She cared for Resident #419 on 03/15/24 and 03/22/24. A progress note written by Nurse #13 on 03/23/24 documented Resident #419 did not receive his antibiotics because he had no IV access. In an interview with the Wound Care Nurse on 06/12/14 at 12:30 PM she stated the Nurse Practitioner (NP) was aware the IV was out. She noted the NP was supposed to come to the facility and restart the IV. She cared for Resident #419 on 03/23/34. In an interview with Nurse #20 on 07/01/24 at 10:10 am she stated she had cared for Resident #419 on 03/16/24, 03/19/24, and 03/21/24. She recalled when she assessed him to start an IV site, she could not find a vein. Multiple unsuccessful attempts were made to contact the NP on 06/12/14 at 1:48 PM and 3:36 PM. She had been employed at the facility in March 2024. An additional attempt was made on 06/13/24 at 3:07 PM with no response. Other attempts were made to contact the NP by different surveyors on the team throughout the survey week with no response. Multiple unsuccessful attempts were made on 06/12/14 at 1:50 PM and 3:33 PM to contact the physician employed at the facility in March 2024. An additional attempt was made on 06/13/24 at 3:00 PM with no response. Other attempts were made to contact the physician by different surveyors on the team throughout the survey week with no response. In an interview with the current Agency DON (Director of Nursing) on 06/12/24 at 1:05 PM she stated she became employed at the facility on 03/25/24. She commented if she had been employed when the facility nurses could not establish IV access, she would have first tried to start the IV herself and if unsuccessful she would have called the provider, obtained an order for a PICC line and would have sent the resident out to have IV access established within 24 hours of the first unsuccessful attempt to re-establish IV access.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to assess, obtain physician orders for treatment, and communicate about the new pressure ulcer so assessments and treatments could be provided for 1 of 5 residents reviewed for pressure ulcers (Resident #119). Findings included: Resident #119's Hospital admission note dated 03/02/24 revealed resident with pressure ulcer of coccygeal region that was present on admission. Resident #119 was admitted from the hospital to the facility on [DATE]. The diagnoses included diabetes, congestive heart disease, end stage renal disease, atrial fibrillation, and hypertension. Review of the head-to-toe skin assessment for Resident #119 dated 04/04/24 done by Nurse #2, identified and documented a Sacrum - small, reddened area to bony prominence, pressure absorbent bandage in place. A nursing note dated 04/05/24 at 2:37 AM by Nurse #10 revealed Resident #119 admitted to facility via stretcher from hospital during day shift. Resident was alert and oriented with some confusion noted and was able to verbalize needs. She had an open area noted to bony prominence of coccyx, and area was cleansed with normal saline and new dressing applied. A telephone interview was conducted with Nurse #10 on 06/12/24 at 10:35 AM. Nurse #10 stated she completed the initial admission skin assessment for Resident #119 on 04/04/24. Nurse #10 explained she noticed Resident #119 had a dressing in place from the hospital on her coccyx covering what looked like an open split skin area on her buttock crack near the sacrum. There was no drainage or odor. She said she removed the old dressing, cleaned the site with normal saline. She also said she did not recall documenting a description of her observation, but she was certain she informed the day nurse of her observation and dressing change and let the wound treatment nurse know of the site. A nursing note dated 04/05/24 at 1:36 PM by Nurse #1 revealed nurse went to assess Resident #119's skin, but she had left facility to go to dialysis and would be back later this PM. Review of the April 2024 Treatment Administration Record (TAR) for Resident #119 revealed the resident received treatment Calmoseptine to buttock with each incontinent episode, apply every day at night shift and to start 04/06/24 at 7:00 PM. The TAR had no documented treatment for the coccyx pressure ulcer. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #119 had no cognitive impairments. She required substantial/maximal physical assistance with bed mobility, transfers, and activities of daily living. She was always incontinent of bowel and frequently incontinent of bladder. Resident #119 was discharged to her home on 04/10/24. (continued on next page)

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	345185	A. Building B. Wing	07/02/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/12/24 at 10:00 AM with the Director of Nursing (DON). The DON stated Nurse #119 documented an observation of an open area noted to bony prominence of coccyx and she cleaned the area with normal saline and applied a new dressing. She acknowledged there was no documenation about Resident #119's coccyx ulcer from admission 04/04/24 through discharge on 04/10/24. An interview was conducted on 06/12/24 at 3:45 PM with Unit Manager #2 (previous treatment nurse). The Unit Manager stated on 04/05/24 the day nurse who received report from Nurse #10 should have reported Resident #119's sacral pressure ulcer to her for evaluation and possible treatment which she did not. An interview was conducted on 06/13/24 at 10:50 AM with the Administrator. She said it was her expectation that Resident #119's admission coccyx pressure ulcer should have been identified, treated, and tracked more closely by nursing staff. An interview was conducted on 06/14/24 at 10:20AM with the Nurse Practitioner (NP). She stated it was her expectation that on 04/05/24 the day nurse assigned to Resident #119 should have reported the coccyx pressure ulcer to the wound treatment nurse that same morning it was reported to her and did not. The NP said all nursing staff are responsible for reporting all wounds timely to the treatment nurse so she can obtain appropriate orders and start treatment. NP stated it was important to her and the treatment nurse to know what wounds were in the facility and what treatments were being utilized, which had not happened in this case.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on observations, record review, resident and staff interviews, the facility failed to supervise a dependent resident (Resident #50) when he was left alone in the shower room on the shower chair and waited for staff to answer the call light and provide assistance for 1 of 7 residents reviewed for accidents. Findings included: Resident #50 was admitted to the facility on [DATE]. Diagnoses included right below the knee amputation with prothesis, coronary artery disease, high blood pressure, chronic kidney disease, and congestive heart failure. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed resident was cognitively intact and demonstrated no behaviors. He required supervision with one person physical assistance with transfers, had impairment one side to lower extremity, used a wheelchair and had limb prosthesis. Resident #50 required partial to moderate assistance with showering and bathing, lower body dressing below the waist, getting in and out of shower, and transferring from chair to wheelchair. He required substantial to maximal assistance with taking off and putting on footwear. Review of Resident #50's care plan dated 10/23/23 revealed a plan of care was in place for resident being independent on meeting emotional, intellectual, and social needs, however, at this time he is dependent on staff to meet some physical needs due to limitations. Interventions included, in part, to converse with resident while providing care, ensure adaptive equipment that the resident needs is provided and present and functional. Additionally, a plan of care was in place for at risk for falls related to gait and balance problems with an interventions to include, in part, call light within reach and requires a prompt response to all requests for assistance. Review of the camera footage timeline on an incident report dated 05/17/24 revealed the following: 10:42 AM Resident #50 entered the shower room. NA #8 followed Resident #50 and entered the shower room. 10:46 AM Nurse Aide #8 exited the shower room 10:48 AM Nurse Aide #8 reentered the shower room 10:49 AM Nurse Aide #8 exited the shower room 11:00 Call light in shower room sounds 11:16 AM Nurse Aide #8 entered the shower room 11:20 AM Nurse Aide #8 and Resident #50 exited shower room and went to Nurse #9 and were telling her something. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #50 on 06/14/24 at 1:00 PM revealed on 05/17/24, he was left unattended in the shower for over 15 minutes. He stated he was on the smoking porch and stated he wanted to get a shower early on this day because he had family coming. Resident #50 stated Nurse Aide (NA) #8 said he was not on her assignment, but that she would get him started in the shower. Resident #50 stated NA #8 took him to the shower and assisted with transferring him to the shower chair from his wheelchair and assisted him with getting undressed, removed his prosthetic leg and turned the shower on. Resident #50 stated he proceeded to bathe himself and washed his hair. He used the call bell to alert for help when he was done. He stated no one came after a few minutes so he turned the water again to keep himself warm and washed himself again while waiting for someone to answer the call bell. He stated he then started to yell for someone to come and help him, but no one came. Resident #50 stated the shower chair did not have wheels like his wheelchair so he was not able to move it easily, but he was able to reach a towel and dry off and reached his prosthetic leg and put it on. He stated he continued to yell, but still no one came. Resident #50 stated he then attempted to transfer himself from the shower chair to the wheelchair but he banged his leg and was not able to transfer himself safely. Resident #50 stated after about 15 minutes, NA #8 finally came back and helped him get out of the shower chair and transferred him to his wheelchair. An interview was conducted NA #8 on 06/14/24 at 2:35 PM. NA #8 reported she was on the smoking porch with Resident #50, and he reported he wanted a shower. He stated his aides from the 100 hall were busy so she told him she would get him in the shower. NA #8 stated she was assigned to the 200 hall, but she helped transfer Resident #50 to a shower chair from his wheelchair and assisted with removing his clothes and his prosthetic leg. She then turned on the water and he began to take his shower. NA #8 stated that she and Nurse #7, who was also assigned to the 200 hall, told Nurse #9 who was assigned to the 100 hall that they were going to the store to get soap which was located across the street and only minutes away. NA #8 stated they were back within 15 minutes or less and when they came back, they saw the shower light going off and Nurse #9 was sitting at the computer at the nursing station. NA #8 stated she went into the shower room and saw Resident #50 was still in the shower. She assisted him with getting dressed and brought him out of the shower room. She stated Resident #50 wanted to know why his aides left him in the shower room. NA #8 stated she was told by the Director of Nursing after it all happened that if she could not stay with a resident while in the shower, then do not give the shower to the resident and to leave it to the assigned nurse aides to do the shower. NA #8 stated she should not have left Resident #50 alone in the shower because no resident should be left alone while they were getting a shower for safety reasons. She stated Resident #50 could wash and dress himself, but he needed assistance with dressing, and he needed assistance pulling himself out of the shower chair to his wheelchair. NA #8 added, Resident #50 needed someone there to get him out of the shower and he was not safe to be left alone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #7 on 06/13/24 at 11:45 AM. Nurse #7, who was not assigned to Resident #50, reported on 05/17/24, Resident #50 was out on the smoking porch and stated he had family coming in to see him today and he wanted a shower and NA #8 said she would give him one. NA #8 assisted Resident #50 in the shower. She stated after he was in the shower, she and NA #8 told Nurse #9 that they were leaving the facility to go to the store across the street to get soap and that Resident #50 was in the shower and for her to let his aides know so they could get him out. Nurse #7 reported they were at store for about 15 minutes and when they came back, the call light was on to the shower room and Nurse #9 was sitting at the nurse's station not answering the light. Nurse #7 stated NA #8 went to the shower room to assist Resident #50 out of the shower. Nurse #7 stated Nurse #9 did not tell the aides that were assigned to Resident #50 that he was in the shower and she did not answer the light when it rang. Nurse #7 stated anytime any resident was getting a shower, the nursing staff was to supervise the resident while in the shower to prevent any accidents and she should have made sure someone was supervising Resident #50 before she left for the store. An interview was conducted with Nurse #9 via phone on 06/13/24 at 2:19 PM. Nurse #9 reported she was the nurse assigned to the 100 hall on 05/17/24 where Resident #50 resided. She stated Resident #50 was upset about being left in the shower room and that no one was answering the call light to assist him. She stated Resident #50 told her that NA #8 had put him in the shower and left. Nurse #9 stated she had learned from NA #8 that she and Nurse #7 left the building to go to the store, but it was not until they returned. Nurse #9 stated neither NA #8 nor Nurse #7 reported to her that Resident #50 was in the shower or that they were going to the store. Nurse #9 stated she did not recall hearing the call light going off. An interview was conducted with NA #4 via phone on 06/18/24 at 10:39 AM. NA #4 reported she had worked at the facility as agency nurse aide for about 8 weeks. She stated she was assigned to Resident #50 on the 100 hall on 05/17/24. NA #4 reported she did not what had actually happened on 05/17/24 but was told someone put Resident #50 in the shower, but they did not inform her or NA #5 who was also assigned to Resident #50. NA #4 reported Resident #50 and Nurse #9 approached her and NA #5 while they were doing resident care for another resident and Resident #50 was yelling at us for leaving him in the shower, but they had no idea he was even in the shower and did not hear the call light because they were in another room down another hall. NA #4 stated whenever she gave Resident #50 a shower, she would assist him getting undressed, removing his prosthetic, and transferring him from the wheelchair to the shower chair. She stated she would provide privacy while he would bathe himself, but that in order to provide safety for the resident, she would not leave the shower area and leave the resident unattended. She stated no resident should be left in the shower area alone because they could fall and hurt themselves. An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 11:00 AM. The DON reported that a nursing staff member should always be with a resident whenever they were getting a shower. The DON stated she did not know NA #8 and Nurse #7 left the building and it was not okay for them to leave without telling anyone. She stated her expectation of nursing staff was that residents should not be left in the shower alone because of the potential for an accident. The DON added Resident #50 had a mobility risk due to his impairment and he required supervision while in the shower.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, staff, Registered Dietitian and Facility Physician interviews, the facility failed to obtain physician ordered weekly weights for 4 of 6 residents reviewed for nutrition and wound care evaluation (Resident #36, Resident #38, Resident #219, Resident #52) and failed to address a Registered Dietitian recommendation for a medication to stimulate appetite for 2 of 6 residents reviewed for nutrition (Resident #36, Resident #38). Findings included: 1. Resident # 36 was admitted on [DATE] with diagnoses which included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and diabetes. Resident # 36's electronic health record included a 2/8/24 physician order for weight on admission then weekly for 3 weeks (4 weights total); then monthly or as specified by the physician. Resident # 36's weight record contained the following: 2/9/2024 10:13 AM 118.7 pounds (lbs.) 2/16/2024 No weight recorded. 2/23/2024 No weight recorded. 3/3/2024 7:06 PM 121.0 lbs. A 3/12/24 Registered Dietitian (RD) note indicated Resident #36 was reviewed. Resident # 36 consumed 25-100 percent of a carbohydrate-controlled diet. RD recommended providing supervision and cueing with meals and a fortified foods diet. A physician order dated 4/4/24 indicated weekly weights for weight monitoring and regular fortified food diet. A 4/9/2024 Registered Dietitian (RD) note indicated Resident #36 was reviewed for weight loss. The note stated resident's current weight on 4/5/24 was 98 lbs. Resident #36's weight was 121 lbs. on 3/3/24 which was a weight loss of 19 percent in 1 month. The RD indicated Resident #36 consumed 0-75% of a mechanical soft diet with supervision. The following recommendations were made obtain a reweigh to verify current weight, weekly weight x 4 weeks, medication to increase appetite and add protein supplement three times per day. Resident #36's weight record indicated the following weights: 4/5/2024 98.0 Lbs. 4/12/2024 No weight recorded. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/19/2024 No weight recorded. 4/20/2024 98.2 Lbs. 4/27/2024 No weight recorded. 5/4/2024 106.4 Lbs. 5/11/2024 No weight recorded. 5/18/2024 No weight recorded. 5/25/2024 No weight recorded. 6/1/2024 No weight recorded. 6/9/2024 No weight recorded. A 5/7/2024 Registered Dietitian note stated in part Resident # 36's weights were reviewed with a gain of 8. 5% in 1 month and a loss of 10.3% in 3 months. The note did not indicate a reason for the weight fluctuations. Resident # 36's care plan revised on 5/14/24 indicated a nutrition at risk problem related to weight loss with interventions to obtain weights per orders, fortified foods, and monitor intake and record. Resident # 36's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident had a severe cognitive impairment, weight of 106 lbs. and was on a physician prescribed weight gain program. An interview was conducted on 6/12/24 at 2:15 PM with the Agency Director of Nursing (DON). The DON stated weights were not consistently obtained. The DON stated the facility required a better system for obtaining weights and addressing nutritional recommendations. The DON stated she expected staff to obtain weights on admission and weekly for 3 weeks following admission. The DON further indicated she expected physician ordered weights would be obtained. Without the monitoring of weights, the RD and physician are not able to evaluate the root cause of weight changes in the residents. An interview was conducted on 6/12/24 at 2:45 PM with the Registered Dietician (RD). The RD stated weights were supposed to be obtained within the first ten days of the month and that was not being done. The RD stated she informed the Administrator and DON several times over the past 3 months that resident weights were a problem, were not being obtained and this had not improved. The RD indicated Resident # 36's weights were not obtained weekly on admission and as ordered. The RD stated weights were necessary to make recommendations, evaluate the resident's nutritional needs and evaluate current interventions. Without accurate weights and obtaining weekly weights as ordered, the RD stated it was difficult to determine the cause of Resident # 36's weight changes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview was conducted with the Director of Nursing (DON) on 6/14/24 at 4:10 PM. The DON stated weights were not obtained timely and accurately. The DON stated she was hired through an agency a few months ago and had not implemented a process for obtaining weights yet but indicated it was an important part of the resident's care and was necessary to evaluate the resident's condition. An interview was conducted with the Facility Physician on 6/18/24 at 1:24 PM. The Facility Physician stated she started in the position on 6/7/24 and indicated monitoring of weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Facility Physician further stated weights were to be obtained as ordered and the recommendations made by the Registered Dietitian should be evaluated and addressed. The Facility Physician stated Resident #36's weights should have been obtained as ordered and the Registered Dietitian recommendations should have been addressed. Attempts were made to interview the previous Physician who was in the position at the facility until 6/6/24. Messages were left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received. Attempts were made to interview the previous Nurse Practitioner (NP) who was in the position at the facility until 6/6/24. Messages were left on 6/12/24 at 3:36 PM and 6/13/24 at 3:07 PM with no return call received. 2. Resident #38 was admitted on [DATE] with diagnosis which included stroke and dementia. Resident # 38's care plan dated 12/15/23 indicated a problem of at nutritional risk for weight loss with the following interventions included physician or Nurse Practitioner to evaluate for failure to thrive, fortified foods, protein supplement and consult with physician regarding order for vitamin or other appetite stimulant and RD consult. Resident # 38's weight record indicated: 12/30/23 91.2 pounds (lbs.). 1/8/2024 89.0 lbs. 1/21/2024 102.0 lbs. 2/5/2024 105.0 lbs. 3/3/2024 89.5 lbs. Resident # 38's physician orders indicated an order for regular diet with fortified foods. A 3/12/24 Registered Dietitian progress note indicated Resident # 38 was reviewed for weight loss trend. A weight of 113.5 Lbs. was recorded on 9/6/23 which indicated a 21.3 percent weight loss over 6 months. Recommendation was made to obtain a reweigh due to weight loss and obtain weekly weight for 4 weeks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 38's physician orders indicated a 3/18/24 order for weekly weights for weight monitoring until 04/15/2024. Resident # 38's weight record indicated: 3/19/2024 89.0 lbs. 3/26/24 no weight recorded. 4/5/2024 93.0 lbs. 4/12/24 no weight recorded. 4/20/2024 83.0 lbs. Resident # 38's 4/22/24 quarterly Minimum Data Set (MDS) indicated a weight of 83 lbs. and weight loss of 5 percent or more in the last month or loss of 10 percent in the last 6 months. An RD progress note dated 4/23/2024 indicated Resident # 38 was reviewed for weight loss. Current weight 4/20/24 83 lbs. A weight of 113 lbs. on 10/11/23 indicated a loss of 18.6 percent over 3 months, and a loss of 26.5 percent over 6 months. Resident # 38 consumed 0-50 percent of a regular fortified foods diet and received a protein supplement. Recommendations included: medication to help increase appetite, obtain weekly weights for 4 weeks and evaluate for failure to thrive and protein calorie malnutrition due to weight loss and decreased appetite. The RD did not indicate a root cause analysis of Resident # 38's weight loss. Resident # 38's physician orders revealed no order dated 4/23/24 or later was entered for weekly weights. Resident # 38's physician orders revealed no order dated 4/23/24 for a medication to help increase appetite. A physician note dated 5/3/24 indicated Resident # 38's weight loss and the 4/23/24 Registered Dietitian recommendation for medication to increase appetite were not addressed. Resident # 38's weight record indicated: 5/2/2024 92.0 lbs. 5/9/24 no weight recorded. 5/17/24 no weight recorded. 5/24/24 no weight recorded. Review of a Nurse Practitioner progress note dated 5/20/24 indicated resident's weight and the 4/23/24 Registered Dietitian recommendation for medication to increase appetite were not addressed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 38's electronic health record included a Registered Dietitian progress note dated 5/30/2024. The progress note indicated Resident # 38 was reviewed for weight loss trend. Current weight 5/2/24 92 lbs. Weight on 11/2/23 was 112 lbs. which indicated a 12.3 lbs. weight loss in 3 months and 17.8 percent loss over 6 months. Recommendations included: medication to help increase appetite and physician evaluation for failure to thrive or protein calorie malnutrition diagnosis. Resident #38's physician orders revealed no order dated 5/30/24 or later was entered for a medication to help increase appetite. Resident #38's electronic health record revealed no physician progress note addressing the 5/30/24 Registered Dietitian recommendation for a medication to increase appetite or evaluation for diagnosis of failure to thrive or protein calorie malnutrition. Attempts were made to interview the previous Physician who was Medical Director until 6/6/24. Messages were left on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with no return call received. Attempts were made to interview the previous Nurse Practitioner (NP) who was employed at the facility until 6/6/24. Messages were left on 6/12/24 at 3:36 PM and 6/13/24 at 3:07 PM with no return call received. An interview was conducted on 6/12/24 at 2:45 PM with the Registered Dietitian (RD). The RD stated weights were to be obtained within the first ten days of the month and that was not being done. The RD indicated she had a concern regarding the accuracy of the weights and reweights were not obtained when there was a weight change. The RD stated she informed the Administrator and the Director of Nursing several times over the past 3 months that resident weights were not obtained and there was no improvement. The RD indicated Resident #38's weights were not obtained as ordered or as recommended and this made it difficult to make recommendations, evaluate the resident's nutritional needs and evaluate current interventions. The RD stated that the nutritional recommendations were not addressed for Resident #38. An interview was conducted with Unit Manager #2 on 06/14/24 at 2:00PM. Unit Manager #2 stated she was responsible for ensuring the weekly and monthly weights were obtained. She stated the order for weekly weights was entered into the computer system for all new admissions. She stated when she selected the order type, she did not select Medication Administration Record (MAR),, but instead selected other orders, no documentation required. She stated by selecting the other orders option, the order would not carry over to the MAR to inform the nursing staff that a weekly weight was due. She stated the weekly weight order also did not populate on the weekly weight order report and that was why the weights were not done. Unit Manager #2 stated she gave a list of weights that were needed to the Nursing Assistants (NAs), but she did not follow up with them to ensure they were obtained. A follow up interview was conducted with the Agency Director of Nursing (DON) on 6/14/24 at 4:10 PM. The DON stated weights were not being done due to a breakdown in the process. The DON stated she expected weights would be obtained timely and accurately. The DON further indicated she was hired through an agency, had only been in the position of DON at the facility for a few months and had not yet implemented a process to obtain weights. The DON indicated nutrition was an important part of the resident's care and weights were necessary to evaluate the resident's condition. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Facility Physician on 6/18/24 at 1:24 PM. The Facility Physician stated she had only been in the position since 6/7/24. The Facility Physician stated obtaining weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Facility Physician further indicated that weights were to be obtained as ordered and the recommendations made by the Registered Dietitian should be evaluated and addressed. The Facility Physician stated Resident #38's weight changes and the recommendation for a medication to stimulate appetite should have been evaluated and addressed. 40044 3. Resident #219 was admitted to the facility on [DATE] with diagnosis including cellulitis of the left lower limb and diabetes. A physician's order dated 05/22/24 for Resident #219 revealed to obtain weight on admission then weekly for three weeks, then monthly or as specified by the physician. A physician's order dated 05/28/24 for Resident #219 revealed to obtain weekly weights for nutrition and wound evaluation. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #219 was cognitively intact. She received wound care and a therapeutic diet. The weight was 191.8 lbs. (pounds). There was no weight loss or gain. The care area assessment indicated to initiate a care plan with interventions for nutritional status. Review of Resident #219's electronic medical record from admission on 05/22/24 through 06/19/24 revealed an admission weight recorded on 05/22/24. The weight was 191.8 lbs. (pounds). There were no other weights recorded. During an interview on 06/14/24 at 10:23 AM Nurse Aide #3 stated she recently started working in the facility and was the assigned Nurse Aide for Resident #219. She stated she was given a list at the beginning of the month of residents that needed monthly weights. She stated if a weekly or daily weight was needed the nurse would let her know. She stated she had not been told to obtain Resident #219's weight. She indicated she had not received a list of residents who needed weights so far this month. During an interview on 06/14/24 at 10:53 AM Nurse #6 stated she was routinely assigned to the 400 hall and to Resident #219. She stated the nurse aides obtained monthly weights and the weights were given to the nurse to enter into the electronic medical record. She stated she was not aware Resident #219 had an order for weekly weights because nothing populated in the electronic medical record to notify her that a weekly weight was needed for Resident #219. During an interview on 06/14/24 at 11:30 AM Nurse Aide #4 stated the unit manager gave them a list of names each month of residents that needed weights. She stated they received the list of names at different times during the month. At times she would get the list of names at the beginning of the month, other times she received the list of names for weights later in the month. She stated she didn't know which residents received weekly weights and the nurse would inform her if a weight was needed. She stated when weights were obtained each month the weights were given to the assigned nurse and the nurse entered the weight into the electronic medical record. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24 at 11:30 AM Nurse Aide #5 stated the unit manager gave them a list of names each month of residents that needed weights. She stated she didn't know which residents received weekly weights and the nurse would inform her if a weight was needed. She indicated when weights were obtained each month the weights were given to the assigned nurse and the nurse entered the weight into the electronic medical record. She stated she didn't typically work the 400 hall and was not aware Resident #219 had orders for weekly weights. During an interview on 06/14/24 at 12:30 PM the Registered Dietician stated there had been issues with getting weights. She stated the Director of Nursing, and the Administrator were aware of the issue, and it was being discussed in their Quality Assurance meetings. She reported that Resident #219 was admitted on [DATE] with cellulitis and an abscess on the groin. She received daily wound care to the area and received nutritional supplements three times a day. She reported Resident#219's BMI (body mass index) was elevated, and the weekly weights were ordered to evaluate her nutrition for wound assessments. She stated she was aware the weekly weights were not getting done and had reported this to Administration. She expected weights to be obtained according to the physician's order. During an interview on 06/14/24 at 1:18 PM the Wound Nurse indicated she was not aware Resident #219 had an order for weekly weights to assess her nutritional needs for wound evaluation. She stated Resident #219 was followed by the wound care physician weekly in the facility and the wound was improving. She indicated the weekly weight order was not on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) and therefore she was not aware of the order. During an interview on 06/14/28 at 2:00 PM Unit Manager #2 indicated she had not followed up on weights. She stated she printed a list of names each month and gave the list to the nurse aides. She stated she did not follow up to ensure weights were obtained and reported to the nurses each month because the Registered Dietician reviewed weights. She indicated that she had not given the list of resident names to the nurse aides to obtain weights for the current month and she was not aware that Resident #219 had orders for weekly weights. During an interview on 06/14/24 at 4:08 PM the Director of Nursing (DON) stated monthly weights were to be done by the 5th of each month and weekly weights should be obtained on the first day of the week. She indicted she was aware that obtaining weights was an issue. She reported staff responsible for obtaining weights had developed bad habits and there had been no accountability. She stated more work was needed and staff education would be provided. A phone interview was conducted with the Physician on 6/18/24 at 1:24 PM. The Physician stated monitoring of weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Physician indicated that weights were to be obtained as ordered and the recommendations made by the Registered Dietitian should be evaluated and addressed. 35173 4. Resident #52 was admitted to the facility on [DATE]. A physician's order dated 05/02/24 for Resident #52 revealed to obtain weights on admission then weekly for three weeks, then monthly or as specified by the physician. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #52's electronic medical record from admission on 05/02/24 through 06/14/24 revealed an admission weight recorded on 05/02/24 which was 192.6 pounds. There were no other weights recorded. The Minimum Data Set admission assessment dated [DATE] revealed Resident #52 was severely cognitively impaired and required set up or clean up assistance with eating. Resident #52 was on a regular diet and her weight was recorded as 193 pounds. There was no weight loss or gain. The care area assessment indicated to initiate a care plan with interventions for nutritional status. An interview was conducted with the Registered Dietitian (RD) on 06/12/24 at 2:45 PM. The RD indicated Resident #52's weights were not obtained weekly as ordered. The RD stated weights were necessary to make recommendations, evaluate the resident's nutritional needs and evaluate current interventions. The RD stated it was difficult to determine the cause of Resident # 52's weight changes without obtaining weekly weights as ordered. The RD stated she was aware the weekly weights were not getting done and had reported it to Administration. An interview was conducted with Nurse #7 on 06/13/24 at 11:45 AM. Nurse #7 reported the nurse aides obtained the monthly weights and the weights were given to the nurse to enter into the electronic medical record. She stated she was not aware Resident #52 had an order for weekly weights because nothing populated in the electronic medical record to notify her that a weekly weight was needed. She stated any newly admitted residents should have weekly weights for one month and then changed to monthly thereafter. An interview was conducted with Nurse Aide (NA) #8 on 06/14/24 at 1:11 PM. NA #8 reported she was usually given a list at the beginning of the month of residents who needed a monthly weight. NA #8 added, if a nurse needed a weekly or daily weight she would let her know. NA #8 stated she had not been told to obtain Resident #52's weight and had not received a list of residents who needed monthly weights as of this time. She stated when the weights were obtained she would give them to the assigned Nurse and she believed they would enter them in the electronic medical record. An interview was conducted with Unit Manager (UM) #2 on 06/14/24 at 2:00 PM. UM #2 stated she was responsible for ensuring the weekly and monthly weights were obtained. She stated with new admissions, part of the admission process was to initiate batch orders for weekly weights. She stated the order for the weekly weights that she entered into the electronic record was not entered correctly to populate to the medication administration record to alert nursing staff that a weight was due. UM #2 added due to this error, the weekly weight order also did not populate on to her weekly weight report so she was not aware that Resident #52 needed weekly weights for 3 weeks and that was why they were not done. An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 4:10 PM. The DON stated weights were not obtained timely and accurately. The DON stated she was hired through an agency a few months ago and had not implemented a process for obtaining weights yet but indicated it was an important part of the resident's care and was necessary to evaluate the resident's condition. An interview was conducted with the Facility Physician on 06/18/24 at 1:24 PM. The Facility Physician stated she started in the position on 06/07/24 and indicated monitoring of weights was the facility's responsibility and was important to evaluate the resident's nutritional status. The Facility Physician further stated weights were to be obtained as ordered.

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, staff, resident, Consultant Pharmacist, and Physician interview, the facility failed to provide effective pain management and manage symptoms of withdraw for 2 of 10 residents (Resident #51 and Resident #46) reviewed for pain management. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not available to administer and resulted in a total of 21 doses of the prescribed medication not administered from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain at up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) per her request on 5/12/24 in the middle of the night where she was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED that evening per her request for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not available to administer on 5/10/24 and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in increased pain at a sustained 8-9 pain level, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Immediate Jeopardy began when the facility failed to provide effective pain management for Resident #51 on 5/9/24 resulting in a pain level of 10 out of 10, and for Resident #46 on 5/12/24 when the resident had increased pain and difficulty sleeping. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Findings included: Gabapentin is an anticonvulsant medication prescribed for seizures and nerve pain. Manufacturer instructions indicated gabapentin caused physical dependence and stopping the medication results in withdrawal symptoms. Within 12 hours after stopping gabapentin, withdrawal symptoms may start and may be severe. Withdrawal symptoms include nausea, insomnia, anxiety, tremors, body aches, increased pain, hallucinations and seizures. 1. Resident #51 was admitted on [DATE] with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities). Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. Review of Resident #51's physician orders revealed an order dated 4/10/24 for methadone 5 mg 2 times per day for pain and an order dated 4/18/24 for baclofen 20 mg 3 times per day for muscle spasms. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #51's care plan revealed a focus dated 11/7/23 of pain due to chronic back pain. The goal indicated resident's pain will be relieved with use of pain medications. Interventions included provide/ administer pain medications as ordered, monitor for complaint of pain and report the need for further interventions. Review of Resident #51's quarterly Minimum Data Set (MDS) dated [DATE] indicated resident was cognitively intact The MDS assessment was coded as received scheduled and as needed pain medication. The pain interview was not assessed. The pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on 4/25/24. The pharmacy record indicated the 92 gabapentin pills from the 4/25/24 supply for Resident #51 were returned to the pharmacy while Resident #51 was in the hospital from 5/5/24 through 5/8/24. The hospital discharge summary dated 5/8/24 indicated Resident #51 was hospitalized from 5/5/24 through the morning of 5/8/24. The hospital discharge summary indicated the order for gabapentin for Resident #51 was unchanged when she returned on 5/8/24. The May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and the documentation of a 9 indicated to see the nursing notes. This MAR did not include routine monitoring of pain using a 0-10 pain scale rating. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/8/24 - The MAR for 5:00 PM indicated Nurse #8 documented a 9 and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy. - The MAR for 9:00 PM indicated Nurse #8 documented a 9 and there was no corresponding nursing note. 5/9/24 - The MAR for 9:00 AM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #8 documented a 9 and there was no corresponding nursing note. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A pain assessment dated [DATE] was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse # 8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 reported increased pain when she did not receive her gabapentin. Nurse # 8 stated Resident # 51 was frustrated about not receiving the medication gabapentin as order. Nurse #8 stated she did not report Resident #51's concerns about not receiving the medication gabapentin to administration and did not have an explanation for why she did not report the concerns. A nursing progress note written by Nurse #8 on 5/10/24 at 3:24 AM indicated Resident #51 reported her legs were numb. The note indicated the writer (Nurse #8) informed Resident #51 there were no interventions for this and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room . The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/10/24 - The MAR for 9:00 AM indicated Nurse # 9 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse # 9 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse # 9 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse # 13 documented a 9 and the corresponding administration record note at 10:12 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. An interview was conducted via phone with Nurse # 9 on 6/13/24 at 2:15 PM. Nurse # 9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse # 9 stated Resident # 51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse # 9 revealed she documented 9 which indicated the medication was not available for the doses. Nurse # 9 stated she did not attempt to obtain medication for Resident #51 and the resident reported pain in her legs. Nurse #9 indicated it was normal for Resident #51 to refuse her shower. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with Nurse #13 on 6/27/24 at 12:50 PM. Nurse #13 revealed she was assigned to Resident #51 on 5/10/24 from 7:00 PM to 7:00 AM. Nurse #13 indicated the ordered medication gabapentin 800 mg was unavailable for the scheduled dose at 9:00 PM. Nurse #13 recalled that Resident #51 normally did not complain of pain other than discomfort from her suprapubic catheter (a tube inserted through the abdomen to drain urine from the bladder). The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/11/24 - The MAR for 9:00 AM indicated Unit Manager #1 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Unit Manager #1 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #14 documented a 9 and the corresponding progress note on 5/11/24 at 4:15 PM indicated gabapentin 800 mg was pending from the pharmacy and the nurse pass on information to next shift to follow up. - The MAR for 9:00 PM indicated Nurse #2 documented a 9 and there was no corresponding nursing note. An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not recall if she made any attempt to obtain the medication for Resident #51 and did not assess Resident #51 for pain. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks and prior to that she worked the 7:00 PM to 7:00 AM shift. Unit Manager #1 stated she was aware that Resident #51 ran out of gabapentin and required emergency room evaluation due to increased pain but did not recall any further details of the situation. Unit Manager #1 stated she did not recall if she had been involved in obtaining the medication gabapentin for Resident #51. A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to the emergency room . Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal. An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated for a chief complaint that the facility had been out of her gabapentin for a couple of days and now she was experiencing full body cramps. The ED Summary stated Resident #51 presented to the ED on 5/12/24 at 4:22 AM and reported she had not had her gabapentin and thought she was in gabapentin withdrawal. While in the ED, at 4:43 AM on 5/12/24 Resident #51 was administered gabapentin 800 mg. The discharge instructions were to restart gabapentin 800 mg 4 times per day, to follow up with her primary care physician and to not stop taking prescription medication for pain suddenly. Resident #51 was discharged back to the facility on [DATE] at 6:11 AM. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM. Nurse #2 stated she was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital during the night on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Nurse #2 stated it looked like Resident #51 was exhibiting withdrawal symptoms. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider and sent Resident #51 to the hospital. Nurse #2 stated medications were frequently not available in the facility, and she had been told by other nurses, although she was not able to recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done about the medications not being available. A progress note written by Nurse #14 on 5/12/24 at 10:09 AM indicated Resident #51 returned from the hospital at approximately 8:00 AM. Unit Manager #1 was made aware on 5/11/24 that Resident #51's gabapentin was not available in the facility and the resident was sent to the emergency room during the night on 5/12/24 to obtain it. The MAR for 5/12/24 revealed Nurse #14 inaccurately documented a 6 for the 9:00 AM, 12:00 PM, and 5:00 PM doses of Resident #51's gabapentin which indicated the resident was in the hospital. (Resident #51 returned from the ED on 5/12/24 at approximately 8:00 AM [per Nurse #14's progress note] and the next scheduled dose of gabapentin was due at 9:00 AM). Attempts were made via phone to interview Nurse #14, a nurse that worked through an agency as needed. Messages left on 6/13/24 and 6/14/24 with no return call received. An ED Summary dated 5/12/24 at 8:50 PM indicated Resident #51 presented with muscle spasms and reported she was unable to get her gabapentin prescription refilled at the nursing facility and was having breakthrough pain. The Medication Administration Record for the ED indicated Resident #51 was administered gabapentin 800 mg on 5/12/24 at 9:12 PM. Resident #51 was discharged back to the facility on [DATE] at 9:41 PM with instructions to continue with gabapentin 800 mg 4 times per day. A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening muscle spasms all over and requested to go to the emergency department. 911 was called for transfer to the emergency room . Resident #51 returned to the facility having received Gabapentin at the emergency room . Resident #51 told the emergency room staff that until she received her Gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. The emergency room physician sent a new prescription for Gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM. The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/13/24 (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The MAR for 9:00 AM indicated Nurse # 15 documented a 9 and the corresponding administration record note at 10:05 AM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. - The MAR for 12:00 PM indicated Nurse # 15 documented a 9 and the corresponding administration record note at 1:41 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. - The MAR for 5:00 PM indicated Nurse # 15 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse # 11 documented a 9 and the corresponding administration record note at 10:52 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy Pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on the night of 5/13/24. A 6/7/24 nursing progress note indicated Resident #51 was transferred to the hospital due to a change in condition. Resident #51 remained in the hospital as of 6/19/24 and was unavailable for interview. An in-person interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 stated there had been delays in receiving refills of gabapentin for the past several months and Resident #51 had gone without medication. Unit Manager #2 was unable to recall if Resident #51 reported pain due to not receiving gabapentin but stated gabapentin was ordered for pain so running out of the medication would cause increased pain. An interview was conducted via phone with Nursing Assistant (NA) #1 on 6/27/24 at 4:17 PM. NA #1 stated she was familiar with Resident #51. NA #1 stated Resident #51 complained of pain at times, but this was not common for her. An interview was conducted via phone with NA #9 on 6/27/24 at 4:40 PM. NA #9 stated Resident #51 complained of leg pain at times. A follow up interview was conducted via phone with Nurse #8 on 6/27/24 at 6:15 PM. Nurse #8 stated she was aware of the potential for withdrawal and adverse effects that Resident #51 may sustain because of not receiving the ordered doses of gabapentin. Nurse #8 stated muscle aches and spasms were signs of withdrawal. An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate). The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe. (continued on next page)

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An in-person interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for Resident #51 resulting in missed doses of the medication ordered for pain. The DON indicated there was confusion regarding the requirements to order and reorder gabapentin and she did not understand the requirements herself. The DON revealed the Consultant Pharmacist had informed her of the problem with gabapentin running out but being new to the DON position, she had not investigated the problem. The DON stated a system was required in the facility to track medication refills, especially medications for pain. An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected pain medication to be administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identified a medication was not available for administration. An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. The Physician further indicated it was not right to withhold medication from a resident and it had the potential for adverse outcome. The Physician revealed Resident #51 being sent to the hospital for evaluation due to increased pain was the outcome of not receiving the scheduled doses of the medication gabapentin as ordered by the physician. She stated it was the responsibility of the facility to obtain the medications, especially pain medications, so they could be administered as ordered. 2. Resident #46 was admitted on [DATE] with diagnosis which included diabetes and neuropathy. Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain. A physician order dated 1/18/24 indicated Resident #46 had a PRN (as needed) order for hydrocodone acetaminophen 5-325 milligrams (mg) every 6 hours as needed for pain. Resident #46's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact. Resident #46 received scheduled and as needed pain medication, pain interview should be conducted, and resident reported no pain in the previous 5 days. A review of the Medication Administration Record (MAR) for 5/1/24 through 5/9/24 revealed Resident #46 was administered the PRN hydrocodone acetaminophen 10 doses with the highest pain level recorded as 8. Gabapentin 800 mg was administered twice per day from 5/1/24 through 5/9/24. An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she worked through an agency and was assigned to work at the facility on 5/6/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she was assigned to Resident #46. Nurse #3 indicated a card of gabapentin was delivered for Resident #46 on 5/6/24 but the medication did not have a controlled substance sign out sheet, so she asked Nurse #2 what to do. Nurse #3 indicated Nurse #2 returned the card of gabapentin for Resident #46 to the pharmacy with the delivery driver. Nurse #3 stated she did not inform the Unit Manager, Director of Nursing (DON), or pharmacy that the medication was returned as she thought Nurse #2 would have done this. (continued on next page)

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	345185	A. Building B. Wing	07/02/2024

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she worked on 5/6/24 from 7:00 PM to 7:00 AM but she was not assigned to Resident # 46. Nurse #2 recalled the gabapentin was delivered from the pharmacy for Resident #46 on 5/6/24 but it did not have a controlled drug sheet attached. Nurse #2 stated she was told by someone, but she could not recall who, to return the medication to the pharmacy with the delivery driver due to no controlled drug sheet. Nurse #2 indicated she did not inform the Unit Manager, DON or pharmacy that the medication was returned as she thought the nurse assigned to Resident #46 would do it. The May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM. The MAR specified the documentation of a 9 indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #46's pain medication: 5/10/24 - The MAR for 9:00 PM indicated Nurse # 3 documented a 9 and there was no corresponding nursing note. - The MAR at 9:51 PM indicated Nurse #3 administered a PRN dose of hydrocodone acetaminophen 5-325 mg for pain. Nurse #3 documented the PRN dose was effective. 5/11/24 - The MAR for 9:00 AM indicated Nurse #6 documented as the medication was administered. - The MAR for 9:00 PM indicated Nurse #3 documented a 9 and there was no corresponding nursing note. - The MAR indicated at 9:43 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for a pain level of 7. Nurse #3 documented the PRN dose was effective. 5/12/24 - The MAR for 9:00 AM indicated Nurse #6 documented a 9. The corresponding nursing note at 9:09 AM indicated awaiting pharmacy delivery of gabapentin. - The MAR for 9:00 PM indicated Nurse #3 documented a 9 and there was no corresponding nursing note. - The MAR indicated at 9:37 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for a pain level of 9. Nurse #3 documented the PRN dose was effective. 5/13/24 - The MAR for 9:00 AM indicated Nurse #6 documented a 9. The corresponding nursing note at 9:44 AM indicated awaiting pharmacy delivery of gabapentin. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The MAR for 9:00 PM indicated Nurse # 17 documented a 9. A pain level of 8 was recorded at 10:50 PM. The corresponding nursing note at 10:53 PM indicated the medication on order from pharmacy. - The MAR indicated at 9:50 PM Nurse #17 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for pain. Nurse #17 documented the PRN dose was effective. 5/14/24 - The MAR for 9:00 AM indicated Nurse # 7 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse # 17 documented a 9 and there was no corresponding nursing note. - The MAR indicated at 9:25 PM Nurse # 17 administered an as needed dose of 5-325 mg hydrocodone acetaminophen. Nurse #17 documented the PRN dose was effective. 5/15/24 - The MAR for 9:00 AM indicated Nurse #7 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse # 17 documented a 9 and there was no corresponding nursing note. 5/16/24 - The MAR for 9:00 AM indicated Unit Manager #2 documented a 9. The corresponding nursing note at 9:17 AM indicated waiting for delivery of gabapentin from pharmacy. - The MAR for 9:00 PM indicated Nurse # 11 documented a 9. The corresponding nursing note on 5/17/24 at 12:40 AM indicated awaiting medication delivery from pharmacy. 5/17/24 - The MAR for 9:00 AM indicated Nurse #5 documented a 9. An administration note dated 5/17/24 at 10:09 AM indicated awaiting medication delivery of gabapentin from pharmacy. - The MAR for 9:00 PM indicated Nurse #2 documented a 9 and there was no corresponding nursing note. A pain level of 7 was recorded at 9:04 PM. An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented 9 on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin and indicated the medication was not administered due to it being unavailable. Nurse #3 stated Resident #46 had pain and was unable to sleep when she did not receive the medication gabapentin. Nurse #3 reported she did not relay Resident #46's reports of increased pain to the physician. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart. Nurse #6 indicated Resident #46 was upset about not receiving her scheduled gabapentin due to having increased pain. Nurse #6 did not report the resident's concerns about pain and did not have an explanation for why. An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse # 17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse # 17 stated she looked for the medication on the medication cart and when she did not see it, she documented it 9, not available. Nurse #17 indicated medications were frequently missing and ran out from the medication cart. Nurse #17 revealed gabapentin was prescribed for pain and Resident #46 exhibited increased pain, irritability and anxiety from not receiving the medication. Nurse #17 did not report Resident #46's symptoms to the physician or administration and did not have an explanation for why. An interview was conducted on 6/13/24 at 3:47 PM with Nurse #16. Nurse #16 was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24 from 7:00 PM to 7:00 AM. Nurse #16 stated she worked at the facility through an agency for about 6 weeks. Nurse #16 stated 9 on the electronic MAR indicated the medication was not available. Nurse #16 indicated she documented 9 for unavailable on Resident #46's MAR on 5/13/24, 5/14/24 and 5/15/24 at 9:00 PM for the scheduled doses of gabapentin. Nurse #16 stated gabapentin was prescribed for pain and Resident #46 reported increased pain and inability to sleep from not receiving her scheduled pain medication. An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 stated she signed for the dose on the electronic MAR on 5/15/24 at 9:00 AM in error. Nurse #7 recalled gabapentin was not available on the medication cart, but she did not attempt to obtain it or notify the physician. Nurse #7 stated Resident #46 was upset and had increased pain when she did not receive the ordered gabapentin. Nurse #7 stated she was aware that gabapentin was prescribed for nerve pain and not receiving the medication would cause the resident to have increased pain. Nurse #7 was unable to explain why she did not report Resident #46's increased pain from not receiving the scheduled doses of gabapentin. An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered, resident reported increased pain. Unit Manager #2 stated she did nothing about Resident #46's medication not being available and did not have an explanation for why. An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated there was a problem with running out of medications and administration was aware of the problem with medication not coming in from pharmacy. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM and did not call the pharmacy to obtain it. Nurse #5 stated Resident #46 reported increased pain. Nurse #5 stated she the medication was on order, so she did not attempt to obtain it. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the prescribed dose for Resident #46 on 5/17/24 and the resident reported pain. Nurse #2 stated she did not call the pharmacy to obtain the prescribed gabapentin for Resident #46. Nurse #2 stated medications were frequently unavailable, and she was informed by other nurses, although she did not recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done. Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM. Messages were left on 6/11/24 and 6/12/24 with no return call received. An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated the facility frequently had trouble obtaining medications. Resident #46 stated she had gone without medications for days at a time on several occasions. Resident #46 reported staff would state the medication was coming from the pharmacy and then it didn't come in. Resident indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not receive her gabapentin. Resident #46 stated it was horrible and the staff told her she would just have to wait it out until the medication came in. An interview was conducted via phone with Nursing Assistant (NA) #1 on 6/27/24 at 4:17 PM. NA #1 stated she was familiar with Resident #46. NA #1 stated Resident #46 complained of pain at times, but this was not common for her. An interview was conducted via phone with NA #9 on 6/27/24 at 4:40 PM. NA #9 stated Resident # 46 was pleasant, quiet and did not usually complain of pain. NA #9 stated Resident #46's normal routine was to get up out of bed to the wheelchair and attend activities daily. An interview was conducted via phone with Nurse #5 on 6/27/24 at 6:44 PM. Nurse #5 stated she was aware that suddenly stopping gabapentin could lead to withdrawal symptoms including insomnia, nausea, tremors and anxiety. Nurse #5 stated the symptoms Resident #46 reported could have been withdrawal symptoms. Review of a 5/27/24 Medication Record Review by the Consultant Pharmacist indicated a medication error was identified in Resident #46's electronic health record. The note indicated gabapentin was marked out of stock for 13 doses in May 2024. The Pharmacist indicated on the note that she checked the pharmacy records and found the pharmacy sent a 30-day supply of the medicatio [TRUNCATED]

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on record review and staff interviews, the facility failed to ensure a physician visit occurred for a resident within 30 days from admission for 1 of 8 sampled residents reviewed for physician visits (Residents #48). Findings included: Resident #48 was admitted to the facility on [DATE]. Her diagnoses included congestive heart failure, dementia, depression, anxiety, pain, seizures, hallucinations, and edema. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #48 had moderate cognitive impairment. Review of Resident #48's Electronic Medical Record (EMR) revealed she was not seen by the attending physician. Review of Resident #48's EMR revealed she was seen by Nurse Practitioner (NP) on 05/14/24. An interview was conducted on 06/14/24 at 11:15 AM with the Administrator. She stated their past Medical Director (MD) was not personally visiting their facility as often as he should have. The Administrator the stated reason for switching MD companies, was for that reason, MD was not visiting on site as often as needed. An interview was conducted on 06/14/24 at 3:45 PM with the Director of Nursing (DON). She stated the previous Medical Director (MD) was not visiting their facility as often as he should have. The DON revealed Resident #48 was admitted on [DATE] and had only been seen by a NP on 05/14/24, but never personally by her attending physician.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45711 Based on record review and staff interview, the facility failed to ensure staff were trained and competent in the process to obtain medications from the pharmacy for 10 of 10 staff (Nurse #8, Nurse #9, Nurse #3, Nurse #6, Nurse #17, Nurse #16, Nurse #7, Unit Manager #1, Unit Manager #2, and the Director of Nursing) reviewed for pharmacy procedures for obtaining medications. Findings included: 1a. Resident #51 was admitted on [DATE]. Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. The May 2024 MAR indicated Resident #51's gabapentin was not administered as ordered from 5/8/24 through 5/13/24 due to the medication not being obtained from the pharmacy. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 indicated she did not know the process for obtaining medications from the pharmacy and had been informed by other nurses, although she did not recall which nurses, that if a medication was not available, they just had to wait for it to come in. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse #9 was assigned to Resident #51 on 5/9/24 and 5/10/24. Nurse #9 stated she did not attempt to obtain medication for Resident #51 and did not know the process for obtaining gabapentin. An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24. Unit Manager #1stated she was unclear about the requirements for reordering gabapentin. An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 stated she had been told by other nurses, although she was not able to recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done about the medications not being available. Nurse #2 indicated she was not familiar with the process at the facility for ordering and reordering medications. 1b. Resident #46 was admitted on [DATE]. Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain. Resident #46's May 2024 Medication Administration Record (MAR) indicated gabapentin was not administered as ordered from 5/10/24 through 5/17/24 due to the medication not being obtained from the pharmacy. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted via phone with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24. Nurse #3 stated she was unaware of the process to obtain the medication and she did not inquire about how to obtain it. An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. She worked with Resident #46 on 5/11/24, 5/12/24, and 5/13/24. Nurse #6 stated she was not aware of the process for obtaining a medication that was not available. An interview was conducted via phone on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse # 17 stated she was assigned to Resident #46 on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated was not aware of the process for obtaining medications for residents. An interview was conducted via phone on 6/13/24 at 3:47 PM with Nurse #16. Nurse #16 was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24. Nurse #16 stated she worked at the facility through an agency for about 6 weeks. Nurse #16 stated she was not aware of the process to obtain medications. An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24. Nurse #7 stated she was unaware of the process for obtaining a medication that was not available. An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she did not know the process for obtaining gabapentin and did not know if a written or electric prescription was needed to reorder gabapentin. Nurse #5 stated she was assigned to Resident #46 on 5/17/24. An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24. She indicated she did not know the process for ordering and reordering medications. An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks. Unit Manager #1 stated she thought gabapentin required a written or electronic prescription to be refilled but it had been a while since she ordered it, so she was not sure. An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 stated she thought a written or electronic prescription was required to obtain a refill of gabapentin, but she was not sure. An interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON indicated there was confusion regarding the requirements to order and reorder gabapentin and she did not understand the requirements herself. An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. She stated nursing staff did not have a comprehensive understanding of what to do when they identified a medication was not available for administration.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41387 Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 17 of 130 days reviewed for sufficient staffing (2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024). Finding included: The Payroll Based Journal (PBJ) report for the first quarter of 2024 (January, February, March) reported the facility without RN coverage for eight consecutive hours per day. A review of the daily census posting sheets for the months of February 2024 to June 9, 2024, reported a constant census greater than 60 residents in the facility and no RN coverage for eight consecutive hours for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024. A review of the daily nursing staffing sheets for the months of February 2024 to June 9, 2024, indicated there was no RN scheduled for at least eight consecutive hours for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024. There was no RN recorded as working eight consecutive hours on the timecard records reviewed for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024. In a phone interview with Unit Manager #2 on 6/19/2024 at 11:57 am, she explained she had been responsible for the schedule since April 30, 2024 and knew there was to be a RN scheduled daily for eight consecutive hours. She explained she tried to ensure a RN was scheduled for at least eight hours a day and would call staff to attempt to cover the days when a RN was not scheduled. She stated when she was unable to schedule an RN for eight consecutive hours for a day, the Director of Nursing (DON) and Administrator were informed, and the unit managers (who were not RNs) covered shifts if needed. In a phone interview with the DON on 6/19/2024 at 10:22 am, she stated when she started at the facility in March 2024 there was not a sufficient number of registered nurses on the schedule to cover the required eight consecutive hours per day of RN coverage. She said due to the census greater than 60 residents consistently, she was not able to serve as the RN coverage and there was an RN on-call daily when not in the facility. She stated the administrative team was aware of not having RN coverage for the eight consecutive hours daily at times due to not having a Minimum Data Set (MDS) Nurse in the facility and RN not scheduled on the weekends. She explained the facility recognized the problem and had worked on hiring registered nurses and had been using agency RN staff. (continued on next page)

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Premier Living and Rehab Center	106 Cameron Street Lake Waccamaw, NC 28450

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview with the Administrator on 6/19/2024 at 12:25 pm, she explained the daily nursing schedule was ultimately the DON responsibility to ensure there was a RN that worked eight consecutive hours daily in the facility and stated since February when she started at the facility, she was aware there was an issue with providing a RN eight consecutive hours daily in the facility. She further explained the resignation of MDS Nurses and the DON's inability to serve as the RN coverage due to a constant daily census greater than 60 residents impacted the facility's inability to provide RN coverage for eight consecutive hours daily. The Administrator stated she hired a MDS Nurse, registered nurses and agency registered nurses to help cover the RN for eight consecutive hours issue and continued to use newspaper ads, fliers and job fairs to recruit RN staff due to resignations of RN staff.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 41387 Based on record review and staff interviews, the facility failed to complete a performance review every 12 months for 1 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (Medication Aide #5). Findings included: Medication Aide #5's personnel file was reviewed and revealed a date of hire of 11/8/2019. The personnel file for Medication Aide #5 did not include evidence a performance review had been completed since the Medication Aide #5's date of hire. A phone interview was conducted on 7/1/2024 at 1:23 pm with Medication Aide #5. During the interview, Medication Aide #5 stated her annual performance evaluation was due in November 2023 and had not received a performance evaluation in the last year. A phone interview was conducted on 6/19/24 at 10:22 am with the Director of Nursing (DON). During the interview, the DON stated since starting at the facility in March 2024, she had not conducted a performance review for Medication Aide #5. The DON did not provide a reason as to why she had not conducted an annual performance review for Medication Aide #5. A phone interview was conducted on 6/19/24 at 12:25 pm with the Administrator who stated the DON was responsible for conducting the annual performance review for Medication Aide #5 and did not know the DON had not conducted the annual performance review.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45711 Based on record review, staff, resident, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, and Physician interview, the facility failed to ensure scheduled medication was obtained and available for administration for 3 of 10 residents (Resident #51, Resident #46, and Resident #8) reviewed for medications. Resident #51 was prescribed gabapentin 800 milligrams (mg) four times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #51 missed a total of 21 doses of the medication from 5/8/24 through 5/13/24. Resident #51 had complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the Emergency Department (ED) on 5/12/24 in the middle of the night after missing 14 doses of the medication. She was treated for acute pain with gabapentin and returned to the facility the same day. Resident #51 missed 3 more doses of gabapentin on 5/12/24 and returned to the ED that evening for worsening muscle spasms. She was again treated for acute pain with gabapentin and returned to the facility where she proceeded to miss 4 more doses of the medication prior to the facility obtaining the medication for administration. Resident #46 was prescribed gabapentin 800 mg two times daily for nerve pain. The medication was not obtained from the pharmacy and Resident #46 missed 14 doses of the medication from 5/10/24 through 5/17/24 resulting in trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Additionally, Resident #8 was prescribed Oxycodone/Acetaminophen (opioid medication) 10/325 mg and this medication was not obtained from the pharmacy resulting in multiple missed doses of the medication. Immediate Jeopardy began on 5/9/24 for Resident #51 when the facility failed to obtain the ordered medication gabapentin from the pharmacy resulting in a reported pain scale of 10 out of 10. Immediate Jeopardy began on 5/12/24 for Resident #46 when the facility failed to obtain the ordered medication gabapentin from the pharmacy resulting in increased pain and difficulty sleeping. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Example #3 was cited at scope and severity E. Findings included: 1. Resident #51 was admitted on [DATE] with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities). Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. Review of Resident #51's quarterly Minimum Data Set (MDS) dated [DATE] indicated resident was cognitively intact and exhibited no behaviors. The MDS assessment was coded as received scheduled and as needed pain medication. The pain interview was not assessed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The pharmacy records indicated a supply of 120 gabapentin 800 mg pills was sent to the facility for Resident #51 on 4/25/24. The pharmacy record indicated 92 gabapentin pills from the 4/25/24 supply for Resident #51 were returned to the pharmacy while Resident #51 was in the hospital from 5/5/24 through 5/8/24. The hospital discharge summary dated 5/8/24 indicated Resident #51 was hospitalized from 5/5/24 through the morning of 5/8/24. The hospital indicated the order for gabapentin for Resident #51 was unchanged when she was discharged on [DATE]. A nursing progress note written by Nurse #8 on 5/8/24 at 4:22 PM revealed Resident #51 returned to the facility from the hospital on 5/8/24 at 2:40 PM. Resident #51's May 2024 Medication Administration Record (MAR) indicated there was no routine pain monitoring. The May 2024 MAR indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and specified the documentation of a 9 indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/8/24 - The MAR for 5:00 PM indicated Nurse #8 documented a 9 and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy. - The MAR for 9:00 PM indicated Nurse #8 documented a 9 and there was no corresponding nursing note. 5/9/24 - The MAR for 9:00 AM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #8 documented a 9 and there was no corresponding nursing note. Following readmission to the facility on [DATE], a pain assessment dated [DATE] was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 stated 9 documented on the MAR indicated the medication was not available. If a medication was not available, she stated she would wait a few days and then notify Unit Manager #1. Nurse #8 indicated she did not know the process for obtaining medications from the pharmacy and had been informed by other nurses, although she did not recall which nurses, that if a medication was not available, they just had to wait for it to come in. Nurse #8 stated she did not recall when, but she knew she notified Unit Manager #1 that Resident #51's gabapentin was not available. Nurse # 8 stated frequently medications were not available. Nurse #8 stated a written or electronic prescription was not required to reorder gabapentin. Nurse # 8 stated Resident #51 was frustrated about not receiving the medication gabapentin as order. A nursing progress note by Nurse #13 on 5/10/24 at 3:24 AM indicated Resident #51 reported her legs were numb. The note indicated the nurse informed Resident #51 there were no interventions for this and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room . The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/10/24 - The MAR for 9:00 AM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #13 documented a 9 and the corresponding administration record note at 10:12 PM indicated the facility was awaiting delivery of gabapentin 800 mg from pharmacy. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse #9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse #9 stated Resident #51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse #9 revealed she documented 9 which indicated the medication was not available for the doses. Nurse #9 indicated Resident #51 refused her shower on 5/9/24 which was not normal for her, reporting she was in too much pain. Nurse #9 stated the facility frequently ran out of medications and did not receive medications on time. Nurse #9 stated she did not attempt to obtain medication for Resident #51 and did not know the process for obtaining gabapentin. Attempts were made to interview Nurse #13 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/11/24 - The MAR for 9:00 AM indicated Unit Manager #1 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Unit Manager #1 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #14 documented a 9 and the corresponding progress note on 5/11/24 at 4:15 PM indicated gabapentin 800 mg was pending from the pharmacy and the nurse pass on information to next shift to follow up. - The MAR for 9:00 PM indicated Nurse #2 documented a 9 and there was no corresponding nursing note. An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not recall if she made any attempt to obtain the medication for Resident #51. She stated she was unclear the requirements for reordering gabapentin and did not assess Resident #51 for pain. Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to emergency room . Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal. An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated for a chief complaint that the facility had been out of her gabapentin for a couple of days and now she was experiencing full body cramps. The ED Summary stated Resident #51 presented to the ED on 5/12/24 at 4:22 AM and reported she had not had her gabapentin and thought she was in gabapentin withdrawal. While in the ED, at 4:43 AM on 5/12/24 Resident #51 was administered gabapentin 800 mg. The discharge instructions were to restart gabapentin 800 mg 4 times per day, to follow up with her primary care physician and to not stop taking prescription medication for pain suddenly. Resident #51 was discharged back to the facility on [DATE] at 6:11 AM. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM and was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider and sent Resident #51 to the hospital. Nurse #2 stated medications were frequently not available in the facility. Nurse #2 stated she had been told by other nurses, although she was not able to recall which nurses, that they just had to wait until the medications came in from the pharmacy and there was nothing that could be done about the medications not being available. A progress note written by Agency Nurse #14 on 5/12/24 at 10:09 AM indicated Resident #51 returned from the hospital at approximately 8:00 AM. Unit Manager #1 was made aware on 5/11/24 that Resident #51 had not received her medications from the pharmacy. Unit Manager #1 wrote down the medication that was needed from the pharmacy. The resident was sent to the emergency room last night to obtain gabapentin. The MAR for 5/12/24 revealed Nurse #14 inaccurately documented a 6 for the 9:00 AM, 12:00 PM, and 5:00 PM doses of Resident #51's gabapentin which indicated the resident was in the hospital. (Resident #51 returned from the ED on 5/12/24 at approximately 8:00 AM [per Nurse #14's progress note] and the next scheduled dose of gabapentin was due at 9:00 AM). Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. Nurse #14 worked at the facility through an agency. A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening muscle spasms all over and requested to go to the emergency department. 911 was called for transfer to the emergency room . Resident #51 returned to the facility having received Gabapentin at the emergency room . Resident #51 told the emergency room staff that until she received her Gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. emergency room physician sent a new prescription for Gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM. An ED Summary dated 5/12/24 at 8:50 PM indicated Resident #51 presented with muscle spasms and reported she was unable to get her gabapentin prescription refilled at the nursing facility and was having breakthrough pain. The Medication Administration Record for the ED indicated Resident #51 was administered gabapentin 800 mg on 5/12/24 at 9:12 PM. Resident #51 was discharged back to the facility on [DATE] at 9:41 PM with instructions to continue with gabapentin 800 mg 4 times per day. The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/13/24 (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The MAR for 9:00 AM indicated Nurse #15 documented a 9 and the corresponding administration record note at 10:05 AM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. - The MAR for 12:00 PM indicated Nurse #15 documented a 9 and the corresponding administration record note at 1:41 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. - The MAR for 5:00 PM indicated Nurse #15 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #11 documented a 9 and the corresponding administration record note at 10:52 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy Pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on the night of 5/13/24. A 6/7/24 nursing progress note indicated Resident #51 was transferred to the hospital due to a change in condition. Resident #51 remained in the hospital as of 6/19/24 and was unavailable for interview. An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks. Unit Manager #1 stated she thought gabapentin required a written or electronic prescription to be refilled but it had been a while since she ordered it so she was not sure. Unit Manager #1 stated she knew gabapentin had to be kept in the narcotic locked box and signed for. Unit Manager #1 stated she was aware that Resident #51 ran out of gabapentin and required emergency room evaluation due to increased pain but did not recall when or how she became aware. Unit Manager #1 indicated she did not recall if she had been involved in obtaining the medication gabapentin for Resident #51. An in-person interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 stated she thought a written or electronic prescription was required to obtain a refill of gabapentin, but she was not sure. Unit Manager #2 stated there had been delays in receiving refills of gabapentin for the past several months and Resident #51 had gone without medication. Unit Manager #2 was unable to recall if Resident #51 had pain due to not receiving gabapentin. Unit Manager #2 stated she had not contacted the pharmacy to obtain the ordered medication gabapentin for Resident #51. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist indicated there was a system process problem with the facility and the ordering and reordering of medications, including gabapentin. The Consultant Pharmacist stated there was confusion in the facility regarding the requirements for ordering and reordering gabapentin and this placed the residents at risk of adverse effects. The Consultant Pharmacist stated she discussed the problems with obtaining medications for administration when the current Director of Nursing (DON) came into the position at the facility (DON started position in the end of March) and made her aware of the concerns. Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate). The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe. The Consultant Pharmacist indicated the pharmacy considered gabapentin a controlled medication for storage and accounting purposes but did not require a written or electronic prescription for refills. An interview was conducted by phone with the Pharmacy Quality Assurance Specialist on 6/12/24 at 11:50 AM. The Pharmacy Quality Assurance Specialist indicated the pharmacy treated gabapentin as a controlled medication in terms in the storage and accounting for it. She stated a written or electronic prescription was not required to obtain the medication from the pharmacy. The Pharmacy Assurance Specialist stated the process for obtaining a refill of the medication gabapentin was the facility sent the refill sticker via fax or completed a refill request in the computer. An in-person interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated she did not know why the medication gabapentin was not available for Resident #51. The DON indicated there was confusion regarding the requirements to order and reorder gabapentin and she did not understand the requirements herself. The DON revealed the Consultant Pharmacist had informed her when she started at the facility at the end of March of the problem with gabapentin not being available. Being new to the DON position, she had not investigated the problem. The DON stated a system was required in the facility to track medication refills. An in-person interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications would be available and administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identify that a medication was not available for administration. An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. The Physician further indicated it was not right to withhold medication from a resident and it had the potential for adverse outcome. The Physician revealed Resident #51 being sent to the hospital for evaluation due to increased pain was the outcome of not receiving the scheduled doses of the medication gabapentin as ordered by the physician. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered. 2. Resident #46 was admitted on [DATE] with diagnosis which included diabetes and neuropathy. Review of Resident # 46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain. (continued on next page)

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	345185	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Living and Rehab Center	106 Cameron Street Lake Waccamaw, NC 28450

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #46's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact with no behaviors. Resident #46 received scheduled and as needed pain medication, pain interview should be conducted, and resident had no pain in the previous 5 days. A physician order dated 1/18/24 indicated Resident #46 had a PRN (as needed) order for hydrocodone acetaminophen 5-325 milligrams (mg) every 6 hours as needed for pain. A review of the Medication Administration Record (MAR) for 5/1/24 through 5/9/24 revealed Resident #46 was administered the PRN hydrocodone acetaminophen 10 doses with the highest pain level recorded as 8. An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she worked on 5/6/24 from 7:00 PM to 7:00 AM and was assigned to Resident #46. Nurse #3 indicated a card of gabapentin was delivered for Resident #46 on 5/6/24 but the medication did not have a controlled substance sign out sheet, so she asked Nurse #2 what to do. Nurse #3 indicated Nurse #2 returned the card of gabapentin for Resident #46 to the pharmacy with the delivery driver. Nurse #3 stated she did not inform the Unit Manager, Director of Nursing (DON), or pharmacy that the medication was returned as she thought Nurse #2 would have done this. An interview was conducted with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she worked on 5/6/24 from 7:00 PM to 7:00 AM but she was not assigned to Resident #46. Nurse #2 recalled the gabapentin was delivered from the pharmacy for Resident #46 on 5/6/24 but it did not have a controlled drug sheet attached. Nurse #2 stated she was told by someone, but she could not recall who, to return the medication to the pharmacy with the delivery driver due to no controlled drug sheet. Nurse #2 indicated she did not inform the Unit Manager, DON or pharmacy that the medication was returned as she thought the nurse assigned to Resident #46 would do it. Review of a Controlled Drug Record for Resident #46 revealed the last dose from the supply of gabapentin delivered on 4/8/24 was signed out by Nurse #7 on 5/10/24 at 8:00 AM bringing the count to 0 pills remaining. Resident #46's May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM. The MAR further indicated there was no routine monitoring of Resident #46's pain level. The May 2024 MAR specified the documentation of a 9 indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #46's pain medication: 5/10/24 - The MAR for 9:00 PM indicated Nurse #3 documented a 9 and there was no corresponding nursing note. - The MAR at 9:51 PM indicated Nurse #3 administered a PRN dose of hydrocodone acetaminophen 5-325 mg for pain. 5/11/24 (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The MAR for 9:00 AM indicated Nurse #6 documented as the medication was administered. - The MAR for 9:00 PM indicated Nurse #3 documented a 9 and there was no corresponding nursing note. A pain level of 7 was recorded at 9:43 PM. - The MAR indicated at 9:43 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen. 5/12/24 - The MAR for 9:00 AM indicated Nurse #6 documented a 9. The corresponding nursing note at 9:09 AM indicated awaiting pharmacy delivery of gabapentin. - The MAR for 9:00 PM indicated Nurse #3 documented a 9 and there was no corresponding nursing note. A pain level of 9 was recorded at 9:37 PM. - The MAR indicated at 9:37 PM Nurse #3 administered a PRN dose of 5-325 mg hydrocodone acetaminophen. 5/13/24 - The MAR for 9:00 AM indicated Nurse #6 documented a 9. The corresponding nursing note at 9:44 AM indicated awaiting pharmacy delivery of gabapentin. - The MAR for 9:00 PM indicated Nurse #17 documented a 9. A pain level of 8 was recorded at 10:50 PM. The corresponding nursing note at 10:53 PM indicated the medication on order from pharmacy. - The MAR indicated at 9:50 PM Nurse #17 administered a PRN dose of 5-325 mg hydrocodone acetaminophen for pain. 5/14/24 - The MAR for 9:00 AM indicated Nurse #7 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse # 17 documented a 9 and there was no corresponding nursing note. - The MAR indicated at 9:25 PM Nurse #17 administered an as needed dose of 5-325 mg hydrocodone acetaminophen. 5/15/24 - The MAR for 9:00 AM indicated Nurse #7 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #17 documented a 9 and there was no corresponding nursing note. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5/16/24 - The MAR for 9:00 AM indicated Unit Manager #2 documented a 9. The corresponding nursing note at 9:17 AM indicated waiting for delivery of gabapentin from pharmacy. - The MAR for 9:00 PM indicated Nurse #11 documented a 9. The corresponding nursing note on 5/17/24 at 12:40 AM indicated awaiting medication delivery from pharmacy. 5/17/24 - The MAR for 9:00 AM indicated Nurse #5 documented a 9. An administration note dated 5/17/24 at 10:09 AM indicated awaiting medication delivery of gabapentin from pharmacy. - The MAR for 9:00 PM indicated Nurse #2 documented a 9 and there was no corresponding nursing note. A pain level of 7 was recorded at 9:04 PM. An interview was conducted with Nurse #3 on 6/13/24 at 1:45 PM. Nurse #3 stated she was assigned to Resident #46 on 5/10/24, 5/11/24, and 5/12/24 from 7:00 PM to 7:00 AM. Nurse #3 stated she documented 9 on 5/10/24, 5/11/24, and 5/12/24 at 9:00 PM for the scheduled doses of gabapentin and indicated the medication was not administered due to it was unavailable. Nurse #3 stated she was unaware of the process to obtain the medication and she did not follow up to obtain the medication. Nurse #3 stated Resident #46 had pain and was unable to sleep which was a change from the norm when she did not receive the medication gabapentin. An interview was conducted with Nurse #6 on 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she administered the prescribed dose of gabapentin on 5/11/24 at 9:00 AM from the emergency medication delivery system as it was not available on the medication cart. Nurse #6 stated she was told by someone, unable to recall who, after she gave the dose from the emergency medication delivery system that she was not to do so since it was not the correct dose. The emergency medication delivery system contained gabapentin 100 mg tablets and Resident #46's physician order was for 800 mg. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart and she did not obtain it from the emergency medication delivery system on 5/12/24 or 5/13/24. Nurse #6 stated she was not aware of the process for obtaining a medication that was not available. An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse # 17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated she looked for the medication on the medication cart and when she did not see it, she documented it 9, not available. Nurse #17 indicated medications were frequently missing and ran out from the medication cart. Nurse #17 stated she did not notify the pharmacy or the provider that the medication was not available. Nurse #17 revealed gabapentin was prescribed for pain and Resident #46 exhibited increased pain, irritability and anxiety from not receiving the medication. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 6/13/24 at 3:47 PM with Nurse #16. Nurse #16 was assigned to Resident #46 on 5/13/24, 5/14/24 and 5/15/24 from 7:00 PM to 7:00 AM. Nurse #16 stated 9 on the electronic MAR indicated the medication was not available. Nurse #16 indicated she documented 9 for unavailable on Resident #46's MAR on 5/13/24, 5/14/24 and 5/15/24 at 9:00 PM for the scheduled dose of gabapentin. Nurse #16 stated gabapentin was not on the medication cart for Resident #46, Nurse #16 stated she worked at the facility through an agency for about 6 weeks. Nurse #16 stated medications were frequently missing from the medication cart. Nurse #16 stated she did not call the pharmacy to obtain the medication. Nurse #16 stated gabapentin was prescribed for pain and not receiving the medication caused Resident #46 increased pain. An interview was conducted with Nurse #7 on 6/13/24 at 11:30 AM. Nurse #7 revealed she was an agency nurse at the facility since March. Nurse #7 was assigned to Resident #46 on 5/14/24 and 5/15/24 from 7:00 AM to 7:00 PM. Nurse #7 stated she did not administer the ordered dose of gabapentin on 5/14/24 and 5/15/24 at 9:00 AM due to it not being available. Nurse #7 stated she signed for the dose on the electronic MAR on 5/15/24 at 9:00 AM in error. Nurse #7 recalled gabapentin was not available on the medication cart, but she did not attempt to obtain it or notify the physician. Nurse #7 stated Resident #46 was upset and had increased pain when she did not receive the ordered gabapentin. Nurse #7 stated she was aware that gabapentin was prescribed for nerve pain and not receiving the medication would cause the resident to have increased pain and should be monitored for this. Nurse #7 was unaware of the process for obtaining a medication that was not available. An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated she thought a written or electronic prescription was required to obtain a refill of gabapentin. Unit Manager #2 stated there had been delays in receiving refills of gabapentin, but she did not know why and Resident #46 had gone without the medication. Unit Manager #2 indicated she was assigned to Resident #46 on 5/16/24 from 7:00 AM to 3:00 PM. Unit Manager #2 stated gabapentin was unavailable for Resident #46 on 5/16/24 at 9:00 AM as ordered, resident had increased pain and she did not attempt to obtain it. Unit Manager #2 stated she did nothing about Resident #46's medication not being available. An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated there was a problem with running out of medications and medications not being available. Nurse #5 stated she used the computer to reorder medications, but they frequently did not come in and she did not know why. Nurse #5 stated administration was aware of the problem with medication not coming in from pharmacy. Nurse #5 stated she did not know if a written or electric prescription was needed to reorder gabapentin. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM, did not call the pharmacy to obtain the medication and observed Resident #46 to have increased pain which was abnormal for the resident. Nurse #5 stated she the medication was on order, so she did not attempt to obtain it. An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the prescribed dose for Resident #46 on 5/17/24 and resident had increased pain. Nurse #2 stated she did not call the pharmacy to obtain the prescribed [TRUNCATED]

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37673 Based on record review and interviews with Consultant Pharmacist, Physician, and staff, the facility failed to act on pharmacy recommendations for 7 of 10 residents (Resident #39, Resident #18, Resident #50, Resident #47, Resident #22, Resident #46 and Resident #8) reviewed for medications. Findings included: 1. Review of the hospital discharge summary dated 05/02/24 for Resident #39 revealed the following physician order: Amoxicillin-Clavulanate 875 MG (Milligram)-125 MG oral one tablet every 12 hours for 7 days for diagnoses of sepsis related to a perirectal abscess and a urinary tract infection (UTI). Resident #39 was admitted to the facility on [DATE] with a diagnosis of a UTI. Review of the physician orders for Resident #39 revealed the following order was entered into the computer system on admission: Amoxicillin 875 MG give 1 tablet by mouth every 12 hours for UTI for 7 days. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had intact cognition. He had an indwelling urinary catheter. He was administered antibiotic medications. Review of the facility MAR (Medication Administration Record) for May 2024 revealed Resident #39 was administered Amoxicillin 875 MG on 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/07/24, 05/08/24, 05/09/24, and 05/10/24 for a total of 14 doses. Review of the Consultant Pharmacist ' s Medication Regimen Review dated 05/27/24 revealed the following recommendation as a Priority: High: This resident was admitted with an order for Amoxicillin/Clavulanate 875 MG BID [twice a day] for 7 days. This was entered into the computer as Amoxicillin 875 MG. This is what the pharmacy sent. Please notify the provider of the medication error to clarify if any additional treatment is needed. Please review with the nurses to ensure they read orders carefully and double check entries. There was no documentation that this pharmacy review was reviewed by nursing or the physician. In an interview with the Consultant Pharmacist on 6/12/24 at 9:50 AM she stated the difference between Amoxicillin and Amoxicillin-Clavulanate was that the addition of Clavulanate helped the Amoxicillin work better and more types of bacteria were affected. She would have expected the provider to be notified to report the medication error and determine if additional treatment was necessary. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an additional interview on 06/26/24 at 1:17 PM with the Consultant Pharmacist she explained during a monthly review before she left the building, she emailed the complete pharmacy report and recommendations to the Agency Director of Nursing (DON). Routinely, she expected recommendations to be addressed before she returned to complete the next monthly review. If she found a recommendation had not been addressed, she would write another recommendation and speak to the DON directly to try and get the recommendation addressed. This recommendation was identified as Priority: High on the Medication Regimen Review and she would have expected the Agency DON to call the physician when she received the report to determine if any additional treatment was needed. In an interview with the current Agency DON on 06/12/24 at 4:40 PM she stated she had not followed up on the pharmacy recommendation and had not notified the provider that the wrong antibiotic had been administered to Resident #39 to determine if further treatment was necessary. She stated she had been aware of the recommendation and was responsible for acting on the recommendation when it was received in May 2024. In an interview with the facility's current physician on 06/19/24 at 9:30 AM she stated she had not been notified that Resident #39 was given the wrong antibiotic. She noted she had just started at the facility last week and was not his doctor when this occurred. However, she reported she had seen Resident #39 yesterday and he was not having any symptoms of a UTI at this time. She did not feel any further intervention was required. She stated she would expect to be notified whenever there was a pharmacy recommendation on her next routine visit to the facility or called if the situation required immediate attention. 2. Resident #18 was admitted to the facility most recently on 06/23/23. Diagnoses included a generalized anxiety disorder. The physician order for Resident #18 dated 11/08/23 indicated Ativan (antianxiety medication) 0.5 mg every 6 hours as needed for anxiety or agitation. This order had no stop date. Review of a pharmacy recommendation titled, Note to Attending Physician/Prescriber, dated 04/25/24, documented: CMS [Centers for Medicare and Medicaid Services] regulations state that PRN [as needed] psychotropics can only be given x 14 days. If the resident requires a PRN psychotropic after 14 days, the physician must provide rationale and indicate the duration for the PRN order. Hospice is not exempt. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had moderately impaired cognition. She received Hospice services and had a life expectancy of less than six months. She did not receive antianxiety medication during this assessment look back period. The active physician orders for Resident #18 as of 6/12/24 indicated the PRN Ativan order initiated on 11/8/23 remained in place. Review of the Medication Administration Record (MAR) from January 2024 through June 2024 for Resident #18 revealed PRN Ativan had been administered on 01/27/24, 04/09/24 and 04/23/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an email received on 6/26/24 at 3:23 pm from the Consultant Pharmacist she explained she had notified the facility through pharmacy recommendations month after month on 12/19/23, 1/26/24, 2/18/24, 3/25/24, 4/25/24 and 5/27/24 to discontinue the PRN psychotropic Ativan or provide a rationale and indicate the duration for the medication. She wrote that she had communicated to the previous DON every month that the report had medication issues that were urgent and needed to be addressed. She also spoke with the previous DON monthly regarding the pharmacy reports. She stated the previous DON never had the reports available when she spoke with her. She had emailed the current Agency DON on 4/29/24 regarding the PRN Ativan order, spoke with her in person in May 2024 and sent her another email on 05/28/24 regarding the Ativan order. She noted hospice was not exempt from this regulation. In an interview with the current Agency DON on 06/13/24 at 4:33 PM she stated she was aware of the 14 day rule for PRN psychotropic medication. She stated she was aware of the pharmacy recommendations regarding the PRN Ativan but had not been able to communicate effectively with the previous physician to get the medication discontinued because there was a personality conflict between them. She stated she had not documented that attempts had been made to discontinue the medication and follow the pharmacy recommendation. She was aware the Consultant Pharmacist had made the request to discontinue the Ativan order in April and May 2024. Multiple unsuccessful attempts were made on 06/12/14 at 1:50 PM and 3:33 PM to contact the previous physician. An additional attempt was made on 06/13/24 at 3:00 PM with no response. Other attempts were made to contact the physician by different surveyors on the team throughout the survey week with no response. In an interview with the facility's current physician on 06/19/24 at 9:30 AM she stated she started working at the facility last week. She was aware of the 14 day rule for PRN psychotropics that applied even if the resident was on hospice services. She was not aware the Consultant Pharmacist had recommended the medication be stopped or reviewed with justification and given a stop date. She expected the facility to notify her of pharmacy recommendations and of PRN psychotropic medications that did not have a stop date during her routine visits to the facility or to be called if a recommendation needed immediate attention. 35173 3. Resident #50 was admitted to the facility on [DATE]. Diagnoses included, in part, coronary artery disease, high blood pressure, chronic kidney disease, and congestive heart failure. A review of a physician's order written on 10/06/23 revealed give one tablet of Carvedilol (a medication to treat coronary artery disease) 12.5 milligrams twice daily and to hold medication for a heart rate less than 60 beats per minute (bpm) or systolic blood pressure (SBP) less than 110 milligrams per mercury (mg/Hg) and administer with meals. A review of Resident #50's medication administration record (MAR) for May 2024 to administer the Carvedilol 12.5 milligrams revealed the following: 05/11/24 the blood pressure recording was 100/59 mm/Hg and the heart rate recording was 59 bpm at 9:00 AM and was signed off by Unit Manager #1 05/15/24 the blood pressure recording was 106/68 mm/Hg at 9:00 AM and was signed off by Nurse #9 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/26/24 the blood pressure recording was 109/63 mm/Hg at 5:30 PM and was signed off by Unit Manager #1 05/27/24 the blood pressure recording was 103/69 mm/Hg at 5:30 PM and was signed off by Unit Manager #1 Review of the Consultant Pharmacist's medication regimen reviewed from 05/01/24 through 05/27/24 revealed this resident has order to hold Carvedilol for SBP less than 110 or heart rate less than 60. This dose was not held as ordered. Please report medication error and review with nurses. An interview was conducted with the Pharmacist Consultant on 06/11/24 via phone at 11:20 AM. The Pharmacist Consultant stated when she completed her medication regimen review she would email the Director of Nursing (DON) the review within a day after she finished her review. She added, she would expect the DON to review the regimen to address any high risk medication concerns right away. The Pharmacist Consultant stated a blood pressure medication is a high risk medication and if there were parameters given in an order, the expectation was that the blood pressure medication would be held according to the physician's order if the reading was outside the parameters. She stated the resident would be at risk for increased hypotension (low blood pressure) or bradycardia (decreased heart rate) if the medication was given. An interview was conducted with the Director of Nursing (DON) on 06/14/24 at 5:00 PM. The DON stated the Pharmacist Consultant sent her the May pharmacy recommendations when she had finished. She stated she did not know the actual date she received it in May. She stated as of this date, she had not reviewed all of the May's pharmacy recommendations and had not notified the physician about the medication error that occurred and she should have addressed this recommendation since it was a high risk medication and warranted attention as soon as possible. A phone interview with the facility Physician on 06/19/24 at 9:30 AM revealed she would have expected to be notified whenever there was a medication error so the error could be addressed when it occurred. 41387 4. Resident #47 was admitted to the facility on [DATE] with diagnoses including a bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows) and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Resident #47's electronic medical record (EMR) revealed the last assessment for Abnormal Involuntary Movement Scale (AIMS), a scale that measures the severity of involuntary movements caused by neuroleptic medications (medications known for their ability to attenuate hallucinations and delusions), was dated 11/06/2023 and reported Resident #47 was not experiencing involuntary movements, an adverse side effect to psychotropic medications. A review of Resident #47's EMR included a physician order dated 2/24/2024 Ingrezza (a medicine that treats body movement disorders) 80 milliigrams (mg) at bedtime for tardive dyskinesia (a drug induced movement disorder that causes involuntary facial tics), and a physician order dated 3/27/2024 for Ziprasidone HCL (an antipsychotic medication used to treat bipolar disorders and schizophrenia) 80 mg twice a day for bipolar disorder. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The monthly Medication Regimen Review (MRR) dated 5/25/24 conducted by the Consultant Pharmacist revealed a recommendation for an AIMS assessment for Resident #47. A review of the May and June 2024 Medication Administration Records (MARs) indicated Resident #47 had received the medications Ingrezza and Ziprasidone HCL daily as prescribed by the physician. In a phone interview with the Consultant Pharmacist on 6/12/2024 at 10:44 am, she explained AIMS assessments were to be completed on residents receiving antipsychotics every six months, and she communicated the pharmacy recommendations for a AIMS assessment for Resident #47 through an email to the Director of Nursing (DON) on 5/25/2024. In an interview with Unit Manager #1 on 6/14/2024 at 11:18 am, she stated pharmacy recommendations were sent to the Director of Nursing (DON), and she had not received a pharmacy recommendation for Resident #47 to receive an AIMS assessment from the DON. She stated there was a communication gap between the DON and herself and understood recommendations not received were left on the fax machine, shredded or lost. She explained AIMS assessments should automatically populate in the EMR for nurses to complete, and she was not aware Resident #47 needed an AIMS assessment In an interview with the Director of Nursing on 6/12/2024 at 10:04 am, she explained due to experiencing internet outages in May 2024, she had not reviewed the May 2024 pharmacy recommendation for Resident #47. When asked why AIMS assessment had not been completed, the DON explained AIMS assessments were generated through the EMR and stated she had just learned how to migrate this information to the EMR. She said she had not provided the unit managers training on the process of adding AIMS assessments as she was planning a training for the week this recertification survey began. 45711 5. Resident # 22 was readmitted to the facility on [DATE]. Review of Resident #22's electronic health record revealed a diagnoses report which included a diagnosis of generalized anxiety disorder. Review of the physician orders for Resident #22 revealed an order dated 3/7/24 for Ativan 0.5 milligrams (mg) give one tablet via gastrostomy tube (a tube surgically placed in the abdomen to provide nourishment, liquids and medications) every 8 hours as needed for anxiety. Review of the March 2024 MAR for Resident #22 revealed on 3/21/24 the resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. Review of a quarterly MDS assessment dated [DATE] revealed Resident # 22 had moderately impaired cognition and received an antianxiety medication. Review of the April 2024 MAR for Resident #22 revealed on 4/5/24 the resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. Review of the May 2024 MAR for Resident #22 revealed on 5/12/24 and 5/21/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 22's electronic health record revealed a Consultant Pharmacist recommendation titled Note to Attending Physician/Prescriber dated 5/27/24 which indicated in part: the resident had an order for a PRN psychotropic medication and Hospice is not exempt. If the resident requires a PRN psychotropic after 14 days, the physician must provide rationale and indicate the duration for the PRN order. The note was checked to continue Ativan PRN x 90 days with a rationale of Hospice. The note was signed by the previous Physician on 5/30/24. Review of the June 2024 MAR for Resident #22 revealed on 6/3/24, 6/16/24 and 6/23/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. In an interview with the Consultant Pharmacist on 06/12/24 at 9:15 AM she stated she notified the facility through a pharmacy recommendation to discontinue the PRN psychotropic medication or provide a rationale and indicate the duration for the medication. The Consultant Pharmacist stated residents receiving Hospice services were not exempt from this regulation. The Consultant Pharmacist indicated there had been problems in the facility under the previous Director of Nursing with the recommendations not being addressed. The Consultant Pharmacist stated when she completed her medication regimen review, she emailed a copy of her review to the Director of Nursing (DON) within a day after she finished. The Consultant Pharmacist stated she expected the DON to review the medication regimen review and address the recommendations right away. Attempts were made via phone to interview the previous Physician on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with messages left. No return call was received. In an interview was conducted with the current Director of Nursing (DON) on 06/13/24 at 4:33 PM. The DON stated she was in the position at the facility since the end of March 2024. The DON stated she was aware of the 14-day regulation for PRN psychotropic medication, and she was aware of the pharmacy recommendations but had not been able to communicate with the previous physician to get the medication discontinued. The DON indicated the Consultant Pharmacist sent her the recommendations via email after her monthly reviews were completed. The DON stated she was responsible for reviewing and addressing the Consultant Pharmacist recommendations. The DON stated she saw the 5/27/24 recommendation for Resident #22 and was aware that the previous physician indicated Hospice on the recommendation and did not provide a stop date or discontinue the as needed psychotropic medication. The recommendation was given to the previous physician to address but the DON indicated she had not had a conversation with him regarding this. An interview was conducted with the current Physician via phone on 6/18/24 at 1:15 PM. The Physician stated she started working at the facility on 6/7/24 and was not familiar yet with the residents, their orders and the systems in the facility. The Physician stated she was aware of the 14-day regulation for PRN psychotropics and that this applied even if the resident was on Hospice services. She expected the facility to notify her of pharmacy recommendations, address the recommendations as indicated and notify her of an as needed psychotropic medication that did not have a stop date. The Physician stated she was not made aware the pharmacy had recommended Resident #22's medication be stopped or reviewed with justification and given a stop date. 6. Resident #46 was admitted on [DATE]. Review of the electronic health record for Resident #46 revealed a diagnosis report which included the diagnosis of diabetes and diabetic nerve pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic health record for Resident #46 revealed a physician order dated 12/6/23 for gabapentin 800 milligrams (mg) twice per day for nerve pain. Review of Resident #46's May Medication Administration Record (MAR) revealed the medication Gabapentin 800 milligrams (mg.) twice per day was recorded as 9 which indicated to see nursing administration progress notes for both scheduled doses on 5/10/24, 5/11/24, 5/12/24, 5/13/24, 5/14/24, 5/15/24, 5/16/24, 5/17/24. Review of Resident #46's electronic health record revealed administration notes were made on 5/12/24, 5/13/24, 5/16/24 and 5/17/24 which indicated awaiting pharmacy delivery of medication gabapentin. Review of a 5/27/24 Medication Record Review by the Consultant Pharmacist indicated a medication error was identified in Resident #46's electronic health record. The note indicated gabapentin was marked out of stock for 13 doses in May 2024. Please review with staff. An interview was conducted via phone with the Consultant Pharmacist on 6/12/24 at 9:15 AM. The Consultant Pharmacist stated when she completed her medication regimen review, she emailed a copy of her review to the Director of Nursing (DON) within a day after she finished. The Consultant Pharmacist stated she expected the DON to review the medication regimen review and address any medication errors right away. An interview was conducted with the Director of Nursing (DON) on 6/13/24 at 4:33 PM. The DON was unable to explain any action that was taken as a result of the Consultant Pharmacist's report dated 5/27/24 that indicated a medication error had been made with Resident #46's gabapentin. The DON stated she had not reviewed the medication error with staff, nor had she completed a medication error incident report. The DON stated the Pharmacist Consultant sent her the May pharmacy recommendations after her review on 5/27/24. The DON stated she did not know the actual date she received it in May. The DON stated as of this date, she had reviewed some of the May pharmacy recommendations but not all of them and she had not notified the physician about the medication error that occurred. The DON indicated she should have addressed this recommendation and that she was responsible for reviewing the pharmacy recommendations. An interview was conducted with the current Physician via phone on 6/18/24 at 1:15 PM. The Physician stated she started working at the facility on 6/7/24. The Physician stated she expected the facility to notify her of pharmacy recommendations. The Physician further stated that all pharmacy recommendations that indicated a medication error occurred should be addressed to ensure that the error does not occur again. 49502 7. Resident #8 was admitted to the facility on [DATE] with diagnoses which included chronic atrial fibrillation, Type 2 Diabetes Mellitus, and pain. A review of Resident #8's electronic medical record (EMR) included the following physician orders: 9/22/23: Ozempic 0.25 or 0.5 mg - inject 1 mg subcutaneously one time a day every Friday for type 2 Diabetes Mellitus (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/19/23: Rivaroxaban 5 mg - 1 tablet by mouth in the evening for atrial fibrillation 8/19/23: Glipizide 10 mg - 1 tablet by mouth two times a day for type 2 Diabetes Mellitus A Pharmacy Consultant Medication Regimen Review (MRR) report dated 5/26/24 read Ozempic weekly dose marked out of stock x 2 doses in April and 1 in May. That is 3 weeks without medication and 6:00 pm meds Montelukast, Rivaroxaban (considered significant med error), Zotrix, Glipizide (significant med error) not charted 6 days so far in May. The pharmacist consultant recommended reporting the errors and reviewing with the nurses. In an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am, stated she was aware of the Pharmacist Consultant Medication Regimen Review (MRR) dated 5/24/24 and did not ignore it. She further stated she felt this report was incorrect and therefore she did not report the medication errors or review the errors with the nurses. During a phone interview with the Pharmacy Consultant on 6/12/24 at 10:15 am revealed the medications were available during April, May and June 2024 and indicated there was a systemic problem with medication administration. She further stated she discussed the problems with medications with the current Director of Nursing (DON) and made her aware of the concerns. She indicated her concerns regarding Resident #8's omissions of the ordered medications was hyperglycemia, increased risk for formation of blood clots, and increased pain.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37673 Based on record review, and Consultant Pharmacist, staff and Physician interviews the facility failed to limit an as needed (PRN) psychotropic medication to 14 days (Resident #18 and Resident #22), provide an appropriate diagnosis for an antipsychotic medication (Resident #269), and monitor for abnormal involuntary movements on a resident receiving an antipsychotic medication (Resident #47) for 4 of 5 residents reviewed for unnecessary medications. Findings included: 1. Resident #18 was admitted to the facility most recently on 06/23/23. Diagnoses included, in part, generalized anxiety disorder. Review of the physician orders for Resident #18 revealed the following order that started on 11/08/23: Ativan 0.5 mg (Milligram)-give one tablet by mouth every 6 hours as needed for anxiety or agitation. Review of the January 2024 MAR (Medication Administration Record) for Resident #18 revealed on 01/27/24 she had been administered PRN Ativan 0.5 mg that had a start date of 11/08/23. Review of the April 2024 MAR for Resident #18 revealed on 04/09/24 and 04/23/24 she had been administered PRN Ativan 0.5 mg that had a start date of 11/08/23. Review of a quarterly MDS assessment dated [DATE] revealed Resident #18 had moderately impaired cognition. She had received scheduled and as needed pain medications during the assessment look back period. She received Hospice services. In an interview with the Consultant Pharmacist on 06/12/24 at 9:50 AM she stated she had notified the facility through pharmacy recommendations month after month to discontinue this PRN psychotropic or provide a rationale and indicate the duration for the medication. She noted residents who received Hospice services were not exempt from this regulation. An additional interview was conducted with the Consultant Pharmacist on 06/26/24 at 1:17 pm. She had filed recommendations on 12/19/23, 01/26/24, 02/18/24, 03/25/24, 04/25/24, and 05/27/24 regarding the ongoing PRN Ativan order. Each month she communicated to the Director of Nursing (DON) that the pharmacy reports had medication issues that were urgent and needed to be addressed. She had spoke with the previous DON monthly through March 2024. She had emailed the Agency DON on 04/29/24 and in May she spoke with the Agency DON in person and sent an email on 05/28/24 regarding the use of the PRN Ativan. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 06/13/24 at 4:33 PM she stated she was aware of the 14 day regulation for PRN psychotropic medication, and she was aware of the pharmacy recommendations but had not been able to communicate with the physician who was the Medical Director at the time to get the medication discontinued because she stated he would not listen to her. She explained she had not documented any attempts to discontinue the medication. In an interview with the facility physician on 06/19/24 at 9:30 AM she stated she started working at the facility last week. She was aware of the 14 day regulation for PRN psychotropics that applied even if the resident was on Hospice services. She was not aware the pharmacy had recommended the medication be stopped or reviewed with justification and given a stop date. She expected the facility to notify her of pharmacy recommendations and of PRN psychotropic medications that did not have a stop date. 45711 2. Resident # 22 was admitted to the facility most recently on 06/22/23. Review of the diagnosis report revealed Resident #22 had a diagnosis of generalized anxiety disorder. Review of the physician orders for Resident #22 revealed an order dated 3/7/24 for Ativan 0.5 milligrams (mg) give one tablet via gastrostomy tube every 8 hours as needed for anxiety. Review of the March 2024 MAR for Resident #22 revealed on 3/21/24 the resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. Review of a quarterly MDS assessment dated [DATE] revealed Resident # 22 had moderately impaired cognition and received an antianxiety medication. Resident #22 was not coded as received Hospice services. Review of the April 2024 MAR for Resident #22 revealed on 4/5/24 resident was administered PRN Ativan 0. 5 mg that had a start date of 3/7/24. Review of the May 2024 MAR for Resident #22 revealed on 5/12/24 and 5/21/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. Review of Resident # 22's electronic health record revealed a Note to Attending Physician/Prescriber dated 5/27/24 which indicated in part: the resident had an order for a PRN psychotropic medication and Hospice is not exempt. If the resident required a PRN psychotropic after 14 days, the physician must provide rationale and indicate the duration for the PRN order. The note was checked to continue Ativan PRN x 90 days with a rationale of Hospice. The note was signed as a telephone order by the previous Physician on 5/30/24. Review of the June 2024 MAR for Resident #22 revealed on 6/3/24, 6/16/24 and 6/23/24 resident was administered PRN Ativan 0.5 mg that had a start date of 3/7/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Consultant Pharmacist on 06/12/24 at 9:15 AM she stated she notified the facility through a pharmacy recommendation to discontinue the PRN psychotropic medication or provide a rationale and indicate the duration for the medication. The Consultant Pharmacist stated residents receiving Hospice services were not exempt from this regulation. Attempts were made via phone to interview the previous Physician on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with messages left. No return call was received. In an interview was conducted with the Director of Nursing (DON) on 06/13/24 at 4:33 PM. The DON stated she was aware of the 14-day regulation for PRN psychotropic medication, and she was aware of the pharmacy recommendations but had not been able to communicate with the physician who was the Medical Director at the time to get the medication discontinued. In an interview was conducted with the Physician via phone on 6/1824 at 1:15 PM. The Physician she stated she started working at the facility on 6/7/24. The Physician stated she was aware of the 14-day regulation for PRN psychotropics and that this applied even if the resident was on Hospice services. She expected the facility to notify her of pharmacy recommendations and of PRN psychotropic medications that did not have a stop date. 3. Resident #269 was admitted on [DATE]. Review of Resident #269's diagnosis report in the electronic health record revealed a diagnosis of toxic encephalopathy (a neurological disorder caused by exposure to toxic substances). Review of Resident #269's hospital discharge summary dated 3/7/24 indicated the resident was to receive haloperidol 2 tablets of 2 milligrams (mg) at bedtime. Resident #269's admission physician orders entered in the computer system on 3/7/24 included haloperidol 20 mg at bedtime for mood. The dose of 20 mg was entered into the computer in error. The order was entered into the computer by the Previous Director of Nursing (DON). Review of a Medication Regimen Review (MRR) dated 3/8/24 for Resident #269 indicated an admission review was completed with no pharmacy recommendations. Review of Resident #269's March 2024 Medication Administration Record (MAR) revealed haloperidol 20 mg was scheduled to be administered at 8:00 PM. The MAR was blank on 3/7/24 for the scheduled 8:00 PM dose. The MAR revealed the medication was electronically signed as administered on 3/8/24, 3/9/24, 3/10/24, 3/11/24, 3/12/24, and 3/13/24. Resident #269's admission Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact, exhibited no behavioral symptoms and had no diagnosis of a psychiatric or psychotic disorder. The medical record indicated Resident #269 was sent to the emergency roiagnom on [DATE] and returned with orders to continue haloperidol 2 tablets of 2 mg at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #269's physician orders revealed an order dated 3/14/24 for haloperidol 2 mg give 1 tablet at bedtime for mood. The order was entered by the previous DON and was discontinued on 3/15/24. Review of the March 2024 MAR for Resident #269 revealed haloperidol 2 mg give 1 tablet at bedtime on 3/14/24 at 8:00 PM was documented with a 9 indicating to see nurses notes. Review of Resident #269's nursing progress notes revealed there was no corresponding note on 3/14/24 at 8:00 PM. Review of Resident #269's physician orders revealed an order dated 3/15/24 for haloperidol 2 mg give 2 tablets at bedtime for mood. Review of the March 2024 MAR for Resident #269 revealed haloperidol 2 mg give 2 tablets at bedtime for mood was administered on 3/15/24, 3/16/24, 3/17/24, 3/18/24 and 3/19/24. Review of a nursing progress note dated 3/20/24 indicated Resident #269 was discharged home. Review of a Home Discharge Plan of Care indicated dated 3/20/24 indicated haloperidol 2 mg take 2 tablets at bedtime for mood was included in the list of discharge medications. An interview was conducted with the Physician on 6/11/24 at 1:15 PM. The physician stated she was in the position at the facility since 6/7/24. The Physician indicated antipsychotic medications including haloperidol were only to be prescribed for specific psychiatric diagnoses. The Physician further stated mood was not an appropriate indication for prescribing an antipsychotic medication and this should have been clarified with the provider when the order was written. An interview was conducted with the Consultant Pharmacist on 6/12/24 at 9:15 AM. The Consultant Pharmacist indicated haloperidol was usually only prescribed in an acute setting with a major psychiatric diagnosis. The Consultant Pharmacist indicated mood was not an appropriate diagnosis for an antipsychotic medication. The Consultant Pharmacist stated the order for haloperidol should have been clarified upon admission on 3/7/24 and return from the emergency roiagnom on [DATE]. An interview was conducted via phone with the Pharmacy Quality Assurance Specialist on 6/12/24 at 11:50 AM. The Pharmacy Quality Assurance Specialist indicated the pharmacy did not receive the hospital discharge summary dated 3/7/24 for Resident #269. The Quality Assurance Specialist stated normally the pharmacist compared the discharge summary and the orders that were entered into the computer and would call the facility for clarification or to report discrepancies. The Pharmacy Quality Assurance Specialist indicated the pharmacist that completed the medication regimen review for Resident #269 on 3/8/24 was no longer employed by the pharmacy. An interview was conducted with the previous Director of Nursing (DON) on 6/13/24 at 1:20 PM via phone. The previous DON stated she entered the orders for Resident #269 when he was admitted to the facility from the hospital on 3/7/24. The previous DON stated she entered the order for haloperidol with the incorrect dose. The previous DON indicated she was not aware mood was not an appropriate diagnosis for haloperidol. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 06/13/24 at 4:33 PM she stated she had been in the position since the end of March 2024. The DON stated she was aware of the regulation for an appropriate diagnosis for psychotropic medication, but she was not in the position when Resident #269 was in the facility. The DON stated mood was not an appropriate diagnosis for an antipsychotic medication. Attempts were made via phone to interview the previous Physician on 6/12/24 at 3:33 PM and 6/13/24 at 3:00 PM with messages left. No return call was received. 41387 4. Resident #47 was admitted to the facility on [DATE] with diagnoses including a bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows) and schizophrenia (a serious mental health condition that affects how people think, feel and behave). The last Abnormal Involuntary Movement Scale (AIMS), a scale that measures the severity of involuntary movements caused by neuroleptic medications (medications known for their ability to attenuate hallucinations and delusions), assessment dated [DATE] in Resident #47's electronic medical record (EMR) reported Resident #47 was not experiencing involuntary movements, an adverse side effect to psychotropic medications. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #47 was cognitively intact and received antipsychotic (medications used to treat mental health conditions) medications on a regular basis. A review of Resident #47's EMR included a physician order dated 2/24/2024 Ingrezza (a medicine that treats body movement disorders) 80 milligrams (mg) at bedtime for tardive dyskinesia (a drug induced movement disorder that causes involuntary facial tics), and a physician order dated 3/27/2024 for Ziprasidone HCL (an antipsychotic medication used to treat bipolar disorders and schizophrenia) 80 mg twice a day for bipolar disorder. Resident #47's monthly Medication Regimen Reviews (MRRs) conducted by the Pharmacist Consultant on 5/25/24 revealed a recommendation for an AIMS assessment for Resident #47. A review the May and June 2024 Medication Administration Record (MAR) recorded Resident #47 had received the medications Ingrezza and Ziprasidone HCL daily as prescribed by the physician. In a phone interview with the Pharmacist Consultant on 6/12/2024 at 10:44 am, she explained AIMS assessments were to be completed on residents receiving antipsychotics every six months, and she communicated the pharmacy recommendations for a AIMS assessment for Resident #47 through an email to the Director of Nursing (DON) on 5/25/2024. In an interview with Unit Manager #1 on 6/14/2024 at 11:18 am, she stated the AIMS assessment for Resident #47 populated onto the EMR screen when due and she had not observed a message to complete an AIMS assessment or received the pharmacy recommendation for an AIMS assessment dated [DATE] from the DON. (continued on next page)

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Premier Living and Rehab Center	106 Cameron Street Lake Waccamaw, NC 28450

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing on 6/12/2024 at 10:04 am, she stated due to Resident #47 receiving antipsychotic medications the nursing staff should be completing an AIMS assessment every three months. When asked why an AIMS assessment had not been completed since 11/6/2023 the DON stated she had not reviewed Resident #47's pharmacy recommendation date 5/25/2024 for an AIMS assessment due to experiencing internet outages in May 2024. The DON explained she had just recently learned how to migrate the AIMS assessments to auto-populate on the EMR and stated she had not provided the unit managers training on the process of auto-populating the AIMS assessments due to the start of this recertification survey the week she planned the training.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and interviews with resident, staff, Consultant Pharmacist, Pharmacy Quality Assurance Specialist, Physician, and Wound Clinic Physician, the facility failed to prevent significant medication errors for 9 of 10 residents reviewed (Resident #269, Resident #51, Resident #46, Resident #419, Resident #39, Resident #32, Resident #10, Resident #50, and Resident #8). Resident #269 was administered 6 doses of haloperidol (antipsychotic medication) 20 milligrams (mg) instead of the ordered dosage of 2 tablets of 2 mg at bedtime and was not administered carvedilol (a medication used to treat heart failure, high blood pressure and chest pain) for 25 of the ordered doses. Resident #269 experienced an elevated pulse and shortness of breath requiring Emergency Department (ED) evaluation on 3/14/24. Resident #51 was not administered 21 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/8/24 through 5/13/24 resulting in complaints of constant pain up to a 10 (on a scale of 0 to 10 with the 10 being the worst pain possible), numbness in her legs, and spasms. She was transferred to the ED twice on 5/12/24 where she was treated for acute pain with gabapentin and returned to the facility. Resident #46 was not administered 14 doses of gabapentin (prescribed for nerve pain) 800 mg from 5/10/24 through 5/17/24 resulting in increased pain, trouble sleeping, anxiety, irritability, nausea, and being unable to complete her normal routine due to pain in her legs. Resident #419 was not administered 6 doses of intravenous (IV) (delivered into the vein) Rocephin (antibiotic) and 7 doses of IV Daptomycin (antibiotic) for treatment of his infected stage 4 sacral (triangular bone at the base of the spine) pressure ulcer. The resident was hospitalized on [DATE] and the 4/26/24 discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection). In addition, the facility: administered 14 doses of Amoxicillin (antibiotic) to Resident #39 instead of the ordered Amoxicillin-Clavulanate; did not administer 34 doses of Resident #32's ordered mirtazapine (antidepressant medication); did not administer 23 doses of Resident #10's ordered tetrabenazine prescribed for the treatment of tardive dyskinesia (involuntary movements such as tongue thrusting, rapid eye blinking, repetitive chewing, that can occur with long term psychotropic use); did not follow the parameters indicated in the physician's order for Resident #50's blood pressure medication resulting in 8 doses not administered as ordered; and did not administer 12 doses of Resident #8's Oxycodone/Acetaminophen (opioid pain medication), 3 doses of Ozempic (anti-diabetic medication), 1 dose of Glipizide (anti-diabetic medication), and 1 dose of Rivaroxaban (anticoagulant). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediate Jeopardy began on: 3/14/24 for Resident #269 when haloperidol and carvedilol were not administered as ordered and the resident required ED evaluation due to shortness of breath and an elevated pulse; 5/9/24 for Resident #51 when gabapentin not being administered as ordered resulted in a 10 out of 10 pain scale; 5/12/14 for Resident #46 when gabapentin not being administered as ordered resulted in increased pain and difficulty sleeping, and on 3/15/24 for Resident #419 when the resident's IV dislodged (came out of her vein) and the nurse was unable to restart the IV to administer the ordered antibiotic. Immediate Jeopardy was removed on 6/15/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Examples #5, #6, #7, #8, and #9 were cited at scope and severity E. Findings included: 1. Review of Resident #269's hospital discharge summary dated 3/7/24 indicated the resident was to receive haloperidol 2 tablets of 2 milligrams (mg) at bedtime for mood and carvedilol 12.5 mg twice per day. Resident #269 was admitted on [DATE] with diagnoses which included congestive heart failure, atrial fibrillation and toxic encephalopathy (a neurological disorder caused by exposure to toxic substances). Resident #269's admission physician orders entered on 3/7/24 included haloperidol 20 mg at bedtime for mood. The order was entered into the computer by the previous Director of Nursing (DON). Resident #269's admission physician orders entered on 3/7/24 did not include carvedilol 12.5 mg as indicated in his hospital discharge summary. Review of Resident #269's medical record revealed the admission assessment was completed by Nurse #9 on 3/7/24 at 3:22 PM. Review of Resident #269's March 2024 Medication Administration Record (MAR) revealed haloperidol 20 mg was scheduled to be administered at 8:00 PM. The MAR was blank on 3/7/24 for the scheduled 8:00 PM dose. The MAR revealed the medication was electronically signed as administered on 3/8/24, 3/9/24, 3/10/24, 3/11/24, 3/12/24, and 3/13/24. The MAR further revealed that Resident #269 did not receive carvedilol 12.5 mg twice daily from admission on 3/7/24 through the morning of 3/14/24 as indicated in the hospital discharge summary. This resulted in 14 missed doses of the medication from admission on 3/7/24 through the morning of 3/14/24. Resident #269's admission Minimum Data Set (MDS) dated [DATE] indicated resident was cognitively intact and received antipsychotic medication. Review of Resident #269's March 2024 MAR revealed vital signs were to be obtained every shift. On 3/14/24 day shift (7:00 AM to 3:00 PM) the following were recorded: Blood pressure 162/90 (elevated), pulse 113 (elevated), respirations 20 and temperature 97.0 degrees Fahrenheit. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #269's electronic health record revealed a nursing progress note written by Nurse #9 dated 3/14/24 at 12:10 PM which indicated resident complained of shortness of breath and stated he did not feel right. Resident #269's vital signs were: blood pressure 136/90, pulse 113 (elevated), respirations 22, temperature 97.5 and oxygen saturation of 98% on 3 liters of oxygen. Resident #269 requested to go to the hospital. On 3/14/24 at 12:25 PM Resident #269 went out of the facility to the emergency department. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:00 PM. Nurse # 9 stated she was no longer employed at the facility. Nurse #9 stated she was assigned to Resident #269 on 3/14/24 when he requested to be sent to the emergency room for evaluation. Nurse #9 stated Resident #269 was not doing well that day. Nurse #9 further stated Resident #269 complained of not feeling well, stating he knew something was wrong, his pulse was elevated, he was short of breath and reported he did not feel good all over. Nurse #9 stated after she sent Resident #269 to the hospital, she reviewed his medications and saw the dose of haloperidol was 20 mg. Nurse #9 stated she did not administer Resident #269 haloperidol on her shift as it was ordered to be given on night shift. Nurse #9 indicated if she saw a dose of 20 mg of haloperidol on the MAR to be given, she would not have given it since it was a higher dose than normally ordered. Nurse #9 stated she would clarify a dose that was higher than normal with the doctor. An Emergency Department (ED) Provider Report dated 3/14/24 at 4:24 PM indicated Resident #269 was evaluated with a chief complaint of shortness of breath. Chest x ray and laboratory tests were obtained with no further treatment required. Vital signs upon discharge from the emergency department were blood pressure 138/88, respirations 18 and oxygen saturation 94 percent. The discharge medication list indicated Resident #269 was to receive in part the medication haloperidol 2 tablets of 2 mg at bedtime and carvedilol 12.5 mg twice per day. There was no indication in the ED report of the significant medication errors with haloperidol or carvedilol. Review of the electronic health record for Resident #269 revealed the resident returned to the facility on [DATE] at 6:44 PM. Review of Resident #269's physician orders revealed an order dated 3/14/24 for haloperidol 2 mg give 1 tablet at bedtime for mood. The order was entered by the previous DON and was discontinued on 3/15/24. Review of the March 2024 MAR for Resident #269 revealed haloperidol 2 mg give 1 tablet at bedtime on 3/14/24 at 8:00 PM was documented with a 9 indicating to see nurses notes. Review of Resident #269's nursing progress notes revealed there was no corresponding note on 3/14/24 at 8:00 PM. Review of Resident #269's physician orders revealed an order dated 3/15/24 for haloperidol 2 mg give 2 tablets at bedtime for mood. Review of Resident #269's electronic health record revealed an incident note written by Nurse #4 on 3/15/2024 at 3:58 PM. The note indicated Resident #269's order for haloperidol was transcribed in the computer incorrectly. The progress note indicated Resident #269 received the incorrect dose of haloperidol on 3/8, 3/9, 3/10, 3/11, 3/12, and 3/13/24. Attempts were made to interview Nurse #4 via phone with messages left on 6/11/24 and 6/12/24 with no return call received. Nurse #4 no longer worked at the facility. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The order for carvedilol 12.5 mg indicated in the 3/14/24 ED discharge summary was not entered into Resident #269's physician orders when the resident returned to the facility. The March 2024 MAR revealed that Resident #269 did not receive carvedilol 12.5 mg twice daily on the evening of 3/14/24 through the morning of 3/20/24 as indicated in the ED discharge summary. This resulted in 12 missed doses of the medication. A nursing progress note dated 3/20/24 at 11:50 AM written by Nurse #7 stated resident was discharged home. An interview was conducted with Nurse #13 via phone on 6/27/24 at 12:50 PM. Nurse #13 was assigned to Resident #269 on 3/8/24 from 7:00 PM to 7:00 AM and administered the haloperidol 20 mg on 3/8/24 at 9:00 PM. Nurse #13 stated she administered the medication as ordered and documented on the MAR. Nurse #13 did not recall any further information regarding the dose of haloperidol. An interview was conducted via phone with Nurse #8 on 6/13/24 at 5:12 PM. Nurse #8 confirmed she was assigned to Resident #269 from 7:00 PM to 7:00 AM on 3/9/24 and she administered haloperidol 20 mg according to the physician order and as documented on the MAR. Nurse #8 stated she did not think about it at the time to clarify or hold the haloperidol due to an excessive dose. An interview was conducted with Unit Manager #1 on 6/13/24 at 9:30 AM. Unit Manager #1 stated she was assigned to Resident #269 on 3/11/24, 3/12/24 and 3/13/24. Unit Manager stated she administered the ordered doses of haloperidol to Resident #269 at 9:00 PM on 3/11/24, 3/12/24 and 3/13/24. Unit Manager #1 stated she did not question the dose or obtain a clarification of the dose prior to administering it. An interview was conducted with Unit Manager #2 on 6/13/24 at 8:15 AM. Unit Manager #2 indicated normally, the floor nurses entered the orders in the computer without verifying the orders with the Physician when a resident was admitted . Unit Manager #2 stated she was not sure who was supposed to fax the orders from the hospital, that she did not do it and she thought it must be someone from administration. Unit Manager #2 confirmed she was assigned to Resident #269 on 3/10/24 and her electronic signature on the MAR indicated she administered the 9:00 PM dose of haloperidol 20 mg. Unit Manager #2 stated it did not occur to her to clarify the dose or hold the haloperidol due to the dose of 20 mg ordered being higher than a usual dose ordered. An interview was conducted via phone with the previous Director of Nursing (DON) on 6/13/24 at 1:20 PM. The previous DON stated she entered the orders into the computer for Resident #269 on 3/7/24 when he was admitted to the facility from the hospital. She stated she entered the order for haloperidol incorrectly. She indicated she did not know why she put the order in incorrectly and couldn't say what happened. The previous DON revealed she was not aware she omitted the order for carvedilol and she did not have an explanation for why other than human error. The previous DON indicated she did not recall if she sent the discharge summary to the pharmacy. The previous DON stated she recalled Resident #269 went to the emergency room but did not know why or the outcome. The previous DON stated she left the position at the facility shortly after the resident was sent to the hospital. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted via phone with the Pharmacy Quality Assurance Specialist on 6/12/24 at 11:50 AM. The Quality Assurance Specialist indicated the pharmacy dispensed 30 tablets of haloperidol 20 mg on 3/7/24 for Resident #269. The Quality Assurance Specialist indicated the pharmacy did not receive the hospital discharge summary dated 3/7/24 for Resident #269. The Quality Assurance Specialist stated normally the pharmacist compared the discharge summary and the orders that were entered and would call the facility for clarification or to report discrepancies. The Quality Assurance Specialist indicated documentation in the pharmacy record indicated the pharmacy did not receive a discharge summary for Resident #269. The pharmacy record indicated the pharmacist called the facility on 3/7/24 and was informed by the previous Director of Nursing (DON) to send all Resident # 269's medications as they were entered into the computer. Precautions indicated to use haloperidol with extreme caution with residents with cardiac arrhythmia. The Quality Assurance Specialist stated there was no dosage warning in the computer for the haloperidol dosage. An interview was conducted via phone with the Consultant Pharmacist on 6/12/24 at 9:15 AM. The Consultant Pharmacist indicated haloperidol 20 mg was a high dose which was usually only prescribed in an acute setting with a major psychiatric diagnosis. The Consultant Pharmacist indicated the high dose of haloperidol had the potential for adverse effects including harm and receiving the medication at that dose for a sustained period increased the likelihood of effects. The Consultant Pharmacist stated adverse effects could include but were not limited to sedation, somnolence, movement disorders, drooling and severe respiratory difficulty. The Consultant Pharmacist stated the haloperidol error was a significant medication error. The Consultant Pharmacist reported the omission of carvedilol could result in harm due to potential for exacerbation of atrial fibrillation (irregular heart rate) and congestive heart failure. The Consultant Pharmacist indicated there was a systemic problem with medication administration in the facility for some time and she addressed this with the current DON when she started in March. The Consultant Pharmacist indicated the pharmacy was supposed to receive a copy of the discharge orders to reconcile that with what was entered into the computer by the facility. An interview was conducted via phone with the Physician on 6/11/24 at 1:00 PM. The Physician stated she was new to the facility having started on 6/7/24. The Physician stated in her career as a physician she had never prescribed a dose of 20 milligrams of haloperidol. The Physician indicated the recommended dose that she would prescribe was 2.5 milligrams to 5 milligrams as a one-time dose for an acute psychotic episode. The Physician further stated 6 doses of 20 mg of haloperidol had the potential for serious adverse effects such as sedation, increased tiredness, and respiratory difficulty. The Physician reported the omission of carvedilol from Resident #269's medication list from admission on 3/7/24 through discharge on 3/20/24 was concerning and had the potential for serious adverse effects including changes in blood pressure, heart rate, shortness of breath and worsening of congestive heart failure. An interview was conducted with the current Director of Nursing (DON) on 6/12/24 at 2:15 PM. The DON indicated the incorrect dose of haloperidol administered to Resident #269 was a significant medication error. The DON stated she was aware of the error with the transcription of Resident #269's orders and stated the error was made by the previous DON. The DON stated she did not recall how she was made aware of the error. The DON stated she expected orders to be transcribed correctly and the discharge summary to be faxed to the pharmacy by the floor nurse. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated it was her expectation that medications would be transcribed and administered correctly. She stated she was unaware of the error that occurred with the transcription of Resident #269's medications. 2. Resident #51 was admitted on [DATE] with diagnosis which included in part: chronic pain syndrome, chronic back pain, rheumatoid arthritis, pressure ulcers, and spastic paraplegia (a disorder that causes progressive weakness, stiffness, tightness, pain and muscle spasms of the lower extremities). Review of Resident #51's physician orders revealed an 11/21/23 order for gabapentin 800 milligrams (mg) 4 times per day for nerve pain. Review of Resident #51's quarterly Minimum Data Set (MDS) dated [DATE] indicated resident was cognitively intact and exhibited no behaviors. The MDS assessment was coded as received scheduled and as needed pain medication. The pain interview was not assessed. The May 2024 Medication Administration Record (MAR) indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and specified the documentation of a 9 indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/8/24 - The MAR for 5:00 PM indicated Nurse #8 documented a 9 and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy. - The MAR for 9:00 PM indicated Nurse #8 documented a 9 and there was no corresponding nursing note. 5/9/24 - The MAR for 9:00 AM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #8 documented a 9 and there was no corresponding nursing note. Following readmission to the facility on [DATE], a pain assessment dated [DATE] was completed by Nurse #9. The pain assessment indicated Resident #51 had pain almost constantly with a pain rating of 10 and the pain made it hard to sleep and day to day activities were limited due to pain. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing progress note by Nurse #9 on 5/9/24 indicated Resident #51 refused a shower due to too much pain. An interview was conducted via phone on 6/13/24 at 5:12 PM with Nurse #8. Nurse #8 stated she was assigned to Resident #51 on 5/8/24 and 5/10/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 stated 9 documented on the MAR indicated the medication was not available. If a medication was not available, she stated she would wait a few days and then notify Unit Manager #1. Nurse #8 stated she did not recall when, but she knew she notified Unit Manager #1 that Resident #51's gabapentin was not available. Nurse #8 stated Resident # 51 was frustrated about not receiving the medication gabapentin as ordered. A nursing progress note written by Nurse #8 on 5/10/24 at 3:24 AM indicated Resident #51 reported her legs were numb. The note indicated the nurse informed there were no interventions for this and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room . The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/10/24 - The MAR for 9:00 AM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #9 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse #13 documented a 9 and the corresponding administration record note at 10:12 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. An interview was conducted via phone with Nurse #9 on 6/13/24 at 2:15 PM. Nurse # 9 was assigned to Resident #51 on 5/9/24 and 5/10/24 from 7:00 AM to 7:00 PM. Nurse # 9 stated Resident # 51's gabapentin was not available on 5/9/24 and 5/10/24 for the scheduled doses at 9:00 AM, 12:00 PM and 5:00 PM. Nurse # 9 revealed she documented 9 which indicated the medication was not available for the doses. Nurse # 9 stated she did not attempt to obtain medication for Resident #51. An interview was conducted via phone with Nurse #13 on 6/27/24 at 12:50 PM. Nurse #13 stated Resident #51's gabapentin was unavailable, and she had not administered it. Nurse #13 stated she did not attempt to obtain the medication for Resident #51. The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/11/24 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The MAR for 9:00 AM indicated Unit Manager #1 documented a 9 and there was no corresponding nursing note. - The MAR for 12:00 PM indicated Unit Manager #1 documented a 9 and there was no corresponding nursing note. - The MAR for 5:00 PM indicated Nurse #14 documented a 9 and the corresponding progress note on 5/11/24 at 4:15 PM indicated gabapentin 800 mg was pending from the pharmacy and the nurse pass on information to next shift to follow up. - The MAR for 9:00 PM indicated Nurse #2 documented a 9 and there was no corresponding nursing note. An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication gabapentin was not available for the scheduled doses at 9:00 AM and 12:00 PM. Unit Manager #1 stated she did not recall if she made any attempt to obtain the medication for Resident #51. Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. A progress note written by Nurse #2 on 5/12/2024 at 3:48 AM indicated Resident #51 complained of pain and spasming and requested to be sent to emergency room . Resident #51 was alert and oriented and stated that symptoms were due to gabapentin withdrawal from not receiving her medication as ordered. An Emergency Department (ED) Summary dated 5/12/24 at 6:11 AM indicated Resident #51 was evaluated for a chief complaint that the facility had been out of her gabapentin for a couple of days and now she was experiencing full body cramps. The ED Summary stated Resident #51 presented to the ED on 5/12/24 at 4:22 AM and reported she had not had her gabapentin and thought she was in gabapentin withdrawal. While in the ED, at 4:43 AM on 5/12/24 Resident #51 was administered gabapentin 800 mg. The discharge instructions were to restart gabapentin 800 mg 4 times per day, to follow up with her primary care physician and to not stop taking prescription medication for pain suddenly. Resident #51 was discharged back to the facility on [DATE] at 6:11 AM. An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:24 PM. Nurse #2 stated she was an agency nurse at the facility and worked from 7:00 PM to 7:00 AM. Nurse #2 was assigned to Resident #51 on 5/11/24 into 5/12/24. Nurse #2 recalled sending Resident #51 to the hospital on 5/12/24 due to uncontrolled pain and not having her prescribed gabapentin on hand in the facility. Resident #51 kept complaining of pain during the shift and was shaking and stating she did not feel well. Resident #51 requested to be sent to the hospital for evaluation and to receive her prescribed medication gabapentin for pain. Nurse #2 stated she notified the provider and sent Resident #51 to the hospital. A progress note written by Nurse #14 on 5/12/24 at 10:09 AM indicated Resident #51 returned from the hospital at approximately 8:00 AM. Unit Manager #1 was made aware on 5/11/24 that Resident #51 had not received her gabapentin and was sent to the emergency room last night to obtain it. (continued on next page)

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	345185	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Living and Rehab Center	106 Cameron Street Lake Waccamaw, NC 28450

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The MAR for 5/12/24 revealed Nurse #14 inaccurately documented a 6 for the 9:00 AM, 12:00 PM, and 5:00 PM doses of Resident #51's gabapentin which indicated the resident was in the hospital. (Resident #51 returned from the ED on 5/12/24 at approximately 8:00 AM [per Nurse #14's progress note] and the next scheduled dose of gabapentin was due at 9:00 AM). Attempts were made to interview Nurse #14 via phone with messages left on 6/13/24 and 6/14/24 with no return call received. A progress note written by Nurse #8 on 5/13/24 at 2:40 AM revealed on 5/12/24 at 7:50 PM the nurse was called to resident's room. Resident #51 complained of worsening muscle spasms all over and requested to go to the emergency department. 911 was called for transfer to the emergency room . Resident #51 returned to the facility having received gabapentin at the emergency room . Resident #51 told the emergency room staff that until she received her gabapentin at the facility, she would continue to go to the emergency room every time she was supposed to get it or at least daily. emergency room physician sent a new prescription for gabapentin 800mg four times per day to facility pharmacy. Resident #51 returned to the facility at 9:41 PM. An ED Summary dated 5/12/24 at 8:50 PM indicated Resident #51 presented with muscle spasms and reported she was unable to get her gabapentin prescription refilled at the nursing facility and was having breakthrough pain. The Medication Administration Record for the ED indicated Resident #51 was administered gabapentin 800 mg on 5/12/24 at 9:12 PM. Resident #51 was discharged back to the facility on [DATE] at 9:41 PM with instructions to continue with gabapentin 800 mg 4 times per day. The MAR and the medication administration notes revealed the following related to Resident #51's gabapentin: 5/13/24 - The MAR for 9:00 AM indicated Nurse #15 documented a 9 and the corresponding administration record note at 10:05 AM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. - The MAR for 12:00 PM indicated Nurse #15 documented a 9 and the corresponding administration record note at 1:41 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy. - The MAR for 5:00 PM indicated Nurse # 15 documented a 9 and there was no corresponding nursing note. - The MAR for 9:00 PM indicated Nurse # 11 documented a 9 and the corresponding administration record note at 10:52 PM indicated the facility was awaiting delivery of gabapentin 800 mg from the pharmacy Pharmacy records indicated a supply of 120 gabapentin pills was sent to the facility for Resident #51 on 5/13/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 6/7/24 nursing progress note indicated Resident #51 was transferred to the hospital due to a change in condition. Resident #51 remained in the hospital as of 6/19/24 and was unavailable for interview. An interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 stated she was in the role of Unit Manager for 3-4 weeks. Unit Manager #1 recalled Resident #51 ran out of gabapentin and required emergency room evaluations due to not receiving the medication. Unit Manager #1 did not recall when or how she became aware of the medication errors of Resident #51 not receiving the ordered medication gabapentin. An interview by phone was conducted with the Consultant Pharmacist on 6/12/24 at 9:14 AM. The Consultant Pharmacist stated she discussed the problems with obtaining medications for administration in March when the current Director of Nursing (DON) came into the position at the facility. The Consultant Pharmacist indicated not receiving gabapentin as ordered could cause increased pain, withdrawal symptoms, and tachycardia (a heart rhythm problem causing elevated heart rate) and was a significant medication error. The Consultant Pharmacist indicated withdrawal symptoms may start within 12 hours and may be severe. An interview was conducted with the Director of Nursing (DON) on 6/12/24 at 2:00 PM. The DON stated Resident #51 not receiving the prescribed medication gabapentin from 5/8/24 through 5/13/24 was a significant medication error. The DON revealed the Consultant Pharmacist had informed her of the problem with gabapentin not being available but being new to the DON position, she had not investigated the problem. The DON stated a system was required in the facility to track medication refills to prevent further significant medication errors due to not obtaining refills. An interview was conducted with the Administrator on 6/14/24 at 4:10 PM. The Administrator stated she expected medications would be administered as ordered by the physician. The Administrator stated nursing staff did not have a comprehensive understanding of what to do when they identified that a medication was not available for administration. An interview via phone was conducted with the Physician on 6/18/24 at 1:20 PM. The Physician indicated the dose of gabapentin ordered, 800 mg 4 times per day was a high dose of medication and it was not recommended to abruptly stop taking the medication due to the potential for withdrawal and severe pain. The Physician stated increased pain was a definite concern due to not receiving the scheduled gabapentin as ordered and it could start within 12 hours. The Physician indicated omission of an ordered medication was a medication error and had the potential for serious adverse outcome. The Physician revealed Resident #51 being sent to the hospital for evaluation due to increased pain was the outcome of not receiving the scheduled doses of the medication gabapentin as ordered by the physician. She stated it was the responsibility of the facility to obtain the medications so they could be administered as ordered. 3. Resident #46 was admitted on [DATE] with diagnosis which included diabetes and neuropathy. Review of Resident #46's physician orders revealed a 12/6/23 order for gabapentin 800 milligrams (mg) 2 times per day for nerve pain. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #46's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact with no behaviors. Resident #46 received scheduled and as needed pain medication, pain interview should be conducted, and resident had no pain in the previous 5 days. Review of a Controlled Drug Record for Resident #46 revealed the last dose from the supply of gabapentin delivered on 4/8/24 was signed out by Nurse #7 on 5/10/24 at 8:00 AM bringing the count to 0 pills remaining. The May 2024 Medication Administration Record (MAR) indicated gabapentin 800 mg was to be administered at 9:00 AM and 9:00 PM and specified the documentation of a 9 indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #46's pain medication: 5/10/24 - The MAR for 9:00 PM indicated Nurse # 3 documented a 9 and there was no corresponding nursing note. 5/11/24 - The MAR for 9:00 AM indicated Nurse #6 documented as the medication was administered. - The MAR for 9:00 PM indicated Nurse #3 documented a 9 and there was no corresponding nursing note. 5/12/24 - The MAR for 9:00 AM indicated Nurse #6 documented a 9. The corresponding nursing note at 9:0 [TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45711 Based on observation and staff interviews, the facility failed to: discard 10 doses of COVID-19 vaccine and a bottle of senna syrup (a liquid laxative medication) that were expired in the South station medication room for 1 of 2 medication rooms reviewed. The facility failed to store an unopened bottle of eye drops in the refrigerator per manufacturer's instructions on the 400-hall medication cart. The facility failed to dispose of 4 bottles of expired eye drops and had an in use inhaler with no resident name, opened date or expiration date on the 200 Hall medication cart. The facility failed to label a tube of eye ointment with an opened and expiration date and failed to discard an expired bottle of atropine solution on the 300 Hall medication cart. This was for 3 of 3 medication carts observed for medication storage. Findings included: 1a. Observation of the South station medication room was conducted on 6/11/24 at 2:30 PM with Unit Manager #1 in attendance. The following expired medications were observed: 14 doses of COVID-19 vaccine were observed with a printed expiration date of 6/2/24 on the box. 8-ounce bottle of Senna syrup with a printed expiration date of 4/24/24 on the label. An interview was conducted with Unit Manager #1 on 6/11/24 at 2:30 PM revealed the nurses on the medication carts were to check for expired medications on the carts. Unit Manager #1 stated the pharmacist checked one of the medication carts each time on her monthly visit. 1b. Observation of the 400-hall medication cart on 6/11/24 at 3:00 PM with Unit Manager #1 in attendance revealed: Resident #421's unopened bottle of latanoprost .005% eye drops with a label which indicated refrigerate until opened. The unopened bottle was noted in the top drawer of the medication cart not refrigerated. An interview was conducted on 6/11/24 at 3:30 PM with Nurse #7. Nurse #7 indicated the Unit Managers asked the nurses to check the medication carts for expired medications and eye drops that required refrigeration, but she did not know who was responsible for making sure it was done. 1c. Observation of the 200-hall medication cart on 6/11/24 at 3:30 PM with Medication Aide (MA) #3 in attendance revealed: Resident #14's opened bottle of Vyzulta 0.024% ophthalmic solution with a date opened of 4/22/24. According to the manufacturer's expiration information, it was good for 8 weeks after opening, or 6/10/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #24's dorzolamide/timolol ophthalmic solution 2-0.5% with a date opened of 4/24/24. The manufacturer instructions indicated to discard 4 weeks after opening. or 28 days, which was 5/22/24. Resident #24's latanoprost 0.005% ophthalmic solution with a handwritten date opened of 5/3/24 and an expiration date of 5/31/24. The manufacturer's instructions indicated to discard 4 weeks, or 28 days after opening. Resident #30's latanoprost 0.005% ophthalmic solution with a handwritten date opened of 5/2/24 and an expiration date of 6/2/24. The manufacturer's instructions indicated to discard 4 weeks or 28 days after opening. An in-use Ventolin inhaler was found on the medication cart with no resident name or dose. There was no label with a date opened or an expiration date. 1d. Observation of the 300-hall medication cart on 6/11/24 at 3:45 PM with MA#3 in attendance revealed: Resident #169's ciloxan ophthalmic ointment 0.3% with no date opened and no expiration date on the label. Resident #20's atropine solution 1% use 1 drop under the tongue every 3 hours as needed. The bottle had a handwritten date opened of 5/9/24 and an expiration date of 6/9/24. An interview was conducted on 6/11/24 at 3:47 PM with MA # 3. MA # 3 indicated she was new to working on the medication cart, so she was not sure, but she thought the Unit Managers checked the medication carts. An interview was conducted with the Director of Nursing (DON) on 6/11/24 at 4:05 PM. The DON stated her expectation was that there would be no expired medications on the medication carts or in the medication rooms. The DON further stated there was a breakdown in the process for checking the medication carts for expired medications and checking that medications were labeled and dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on record review, and staff, Pharmacy Technician, and Consultant Pharmacist interviews the facility failed to accurately document on the Medication Administration Record (MAR) the administration of medications for 2 of 10 residents (Resident #10 and Resident #8) reviewed for medications. Findings included. 1. A physician's order dated 03/06/24 for Resident #10 revealed Tetrabenazine 25 milligrams (mg) oral tablets. Give 2 tablets by mouth in the morning for Tardive Dyskinesia. Review of the Medication Administration Record (MAR) dated May 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily at 9:00 AM was signed off as administered on the following dates and time. 05/14/24 at 9:00 AM 05/16/24 at 9:00 AM 05/19/24 at 9:00 AM 05/21/24 at 9:00 AM 05/22/24 at 9:00 AM 05/23/24 at 9:00 AM 05/29/24 at 9:00 AM Review of the Medication Administration Record (MAR) dated June 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily at 9:00 AM was signed off as administered on the following dates and time. 06/01/24 at 9:00 AM 06/02/24 at 9:00 AM 06/04/24 at 9:00 AM 06/06/24 at 9:00 AM 06/09/24 at 9:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 06/13/24 at 2:00 PM Pharmacy Technician #1 stated the initial order for Tetrabenazine 25 mgs for Resident #10 was originally filled and sent to the facility on [DATE]. The Pharmacy dispensed 60 tablets which was a 30-day supply. She stated they dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed anymore of the medication since 04/06/24 because they needed to get prior authorization to continue to fill the medication. She stated they did not refill the medication after 05/06/24 and indicated the medication would not have been available in the facility for administration after 05/06/24. During an interview on 06/13/24 at 2:15 PM the Consultant Pharmacist stated according to the pharmacy records Tetrabenazine 25 mgs had not been dispensed from the pharmacy since 05/06/24 due to waiting on a prior authorization form. She indicated the medication would not have been available in the facility for administration after 05/06/24. During an interview on 06/12/24 at 3:00 PM Nurse #7 stated Resident #10 had been out of the Tetrabenazine 25 mgs for a while, and they were waiting on pharmacy to refill the medication. She reported that she called the pharmacy yesterday on 06/12/24 to ask about the medication and they informed her they were waiting for the prior authorization form to be returned from the facility before they could refill the medication. She stated if she signed off on the MAR that the Tetrabenazine 25 mgs was administered to Resident #10 on 06/06/24 when the medication was not in the facility then it was done in error. During an interview on 06/13/24 at 3:25 PM Unit Manager #2 stated she didn't know why she signed off on the MAR that she administered Tetrabenazine 25 mgs to Resident #10 on 05/16/24, 05/22/24, 05/29/24, 06/01/24, 06/02/24, and 06/09/24 when the medication was not in the facility. She indicated it was done in error. During an interview on 06/13/24 at 3:49 PM Nurse #6 stated if she signed off on the MAR that she administered Tetrabenazine 25 mgs to Resident #10 on 05/21/24 when the medication was not in the facility then it was done in error. An attempt was made to contact Nurse #9 on 06/13/24 at 04:01 PM Nurse #9 documented on the MAR that she administered Tetrabenazine 25 mgs to Resident #10 on 05/23/24 when the medication was not in the facility. There was no response. During an interview on 06/14/24 at 10:57 AM Unit Manager #1 stated if she signed off on the MAR that the Tetrabenazine 25 mgs was administered to Resident #10 on 05/14/24 when the medication was not in the facility then it was done in error. During a phone interview on 06/14/24 at 3:00 PM Nurse #19 stated if she signed off on the MAR that the Tetrabenazine was administered to Resident #10 on 05/19/24 when the medication was not in the facility then it was done in error. During an interview on 06/14/24 at 3:30 PM the Director of Nursing (DON) stated she was not aware that Resident #10 did not have Tetrabenazine available during May and June 2024. She reported the nurses should not have signed off on the MAR that the medication was administered if they didn't have the medication in the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24 at 3:30 PM the Administrator stated she expected that the nurses were accurately documenting medication administration on the residents MAR. She stated education would be provided. 49502 2. Resident #8 was admitted to the facility on [DATE] with diagnoses which included chronic atrial fibrillation, Type 2 Diabetes Mellitus, and pain. Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was cognitively intact. Review of the physician orders for Resident #8 revealed the following: 8/19/23: Rivaroxaban 15 mg - 1 tablet by mouth in the evening for atrial fibrillation 8/19/23: Glipizide 10 mg - 1 tablet by mouth two times a day for type 2 Diabetes Mellitus 2/28/24: Oxycodone/Acetaminophen 5/325 mg - 1 tablet by mouth one time a day for pain 2/28/24: Oxycodone/Acetaminophen 10/325 mg - 1 tablet by mouth one time a day for pain a. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 10/325 mg was scheduled to be administered at 8:00 am and 8:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen: 4/6/24 at 8:00 pm 4/7/24 at 8:00 am 4/7/24 at 8:00 pm During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medication for Resident #8 but forgot to document in EMR the medication was given. The narcotic count sheet reviewed indicated her signature at 8:00 am. In an interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she could not recall if she gave this medication on at 8:00 pm. The narcotic count sheet reviewed indicated her signature at 8:00 pm for the medication. b. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 5/325 mg was scheduled to be administered at 2:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/7/24 at 2:00 pm 4/16/24 at 2:00 pm 4/19/24 at 2:00 pm During a phone interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medication for Resident #8 but forgot to document in EMR the medication was given. The narcotic count sheet reviewed indicated her signature at 2:00 pm. c. The May 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 5/325 mg was scheduled to be administered at 2:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen: 5/11/24 at 2:00 pm 5/30/24 at 2:00 pm d. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Oxycodone/Acetaminophen 5/325 mg was scheduled to be administered at 2:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Oxycodone/Acetaminophen: 6/6/24 at 2:00 pm e. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Rivaroxaban 15 mg was scheduled to be administered at 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Rivaroxaban: 4/7/24at 6:00 pm 4/16/24 at 6:00 pm 4/19/24 at 6:00 pm 4/20/24 at 6:00 pm 4/21/24 at 6:00 pm 4/24/24 at 6:00 pm 4/29/24 at 6:00 pm (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medication for Resident #8 but forgot to document in EMR the medication was given. In an interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she could not recall if she gave this medication on 4/21/24 at 6:00 pm. f. The May 2024 Medication Administration Record (MAR) indicated Resident #8's Rivaroxaban 15 mg was scheduled to be administered at 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Rivaroxaban: 5/5/24 at 6:00 pm 5/9/24 at 6:00 pm 5/10/24 at 6:00 pm 5/11/24 at 6:00 pm 5/21/24 at 6:00 pm 5/22/24 at 6:00 pm 5/27/24 at 6:00 pm 5/29/24 at 6:00 pm In an interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she did not recall if she gave this medication on 6/9/24 at 6:00 pm. g. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Rivaroxaban 15 mg was scheduled to be administered at 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Rivaroxaban: 6/2/24 at 6:00 pm 6/9/24 at 6:00 pm During a phone interview with MA #3 on 6/28/24 at 12:31 pm, she stated the Rivaroxaban was not given. She further stated she was unable to administer this specific medication. She informed Unit Manager #1, the nurse covering her, that she did not give this medication. In a phone interview with Unit Manager #1 on 6/28/24 at 1:00 pm, she stated she did cover the medication aides working on the medication carts, but she could not recall if she gave this medication on 6/9/24 at 6:00 pm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with MA #6 on 6/28/24 at 12:48 pm, she indicated she was an MA and an NA at the facility. She indicated on 6/9/24 she was performing the job responsibilities of an MA and had given the medication but could not recall if she had documented administration in the computer. h. The April 2024 Medication Administration Record (MAR) indicated Resident #8's Glipizide 10 mg was scheduled to be administered at 8:00 am and 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Glipizide: 4/7/24 at 8:00 am 4/7/24 at 6:00 pm 4/16/24 at 6:00 pm 4/19/24 at 6:00 pm 4/20/24 at 6:00 pm 4/21/24 at 6:00 pm 4/24/24 at 6:00 pm 4/29/24 at 6:00 pm During an interview with Nurse #19 on 6/28/24 at 12:00 pm, she explained Resident #8 was listed in electronic medical record (EMR) as unassigned since moving to her new room. She further stated she had to click out of one screen and go into another screen to document medication administration for Resident #8. She indicated she gave the medications for Resident #8 but forgot to document in EMR the medications were given. i. The May 2024 Medication Administration Record (MAR) indicated Resident #8's Glipizide 10 mg was scheduled to be administered at 8:00 am and 6:00 pm. This MAR and the medication administration notes revealed no medication documentation related to Resident #8's Glipizide: 5/5/24 at 6:00 pm 5/9/24 at 6:00 pm 5/10/24 at 6:00 pm 5/11/24 at 6:00 pm j. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Glipizide 10 mg was scheduled to be administered at 8:00 am and 6:00 pm. This MAR and the medication administration notes revealed no medication administration documentation related to Resident #8's Glipizide: 6/2/24 at 6:00 pm (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/9/24 at 6:00 pm During a phone interview with MA #3 on 6/28/24 at 12:31 pm, she stated she does not recall if she administered this medication. During a phone interview with MA #6 on 6/28/24 at 12:48 pm, she indicated she was an MA and an NA at the facility. She indicated on 6/9/24 she was performing the job responsibilities of an MA and had given the medication but could not recall if she had documented administration in the computer. k. The June 2024 Medication Administration Record (MAR) indicated Resident #8's Ozempic was scheduled to be administered at 8:00 am every Friday and specified. This MAR and the medication administration notes revealed no medication administration related to Resident #8's Ozempic: 6/7/24 at 8:00 am In an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am, stated there was a problem in the facility with the nurses documenting 9 on the MAR for medications not available. She indicated she was trying to hold the nurses accountable for accurate medication documentation. During a phone interview with the Administrator on 6/28/24 at 4:10 pm, she stated she expected pain medication to be administered as ordered by the physician.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on record review, staff interviews, and hospice staff interviews the facility failed to maintain communication and coordination of services provided by hospice in the medical record complete with hospice admission documentation, hospice plan of care, and hospice visit notes in the facility's electronic medical record and failed to obtain physician orders for hospice services for 1 of 1 resident reviewed for hospice (Resident #48). Findings included: Resident #48 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, dementia, seizures, and edema. Review of Resident #48's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had moderate cognitive impairment. Resident #48 was coded as receiving Hospice services while a resident. A review of Resident #48's medical record revealed no evidence of the following: physician order for hospice services, hospice plan of care, facility hospice care plan, hospice certification statement, hospice nursing visit record forms, and no election of hospice form. The only documented hospice record found for Resident #48 were seven (7) notes written by facility nurses regarding hospice visits, but no hospice notes were present in resident's medical record. An interview was conducted on 06/13/24 at 9:35 AM with the Director of Nursing (DON). She revealed that it was her expectation that Hospice should have communicated more fully to facility staff. She said hospice failed to provide them with Resident #48's complete hospice record complete with hospice admission documentation, hospice plan of care, hospice visit notes, and documented hospice physician order. The DON said it was her expectation that there be a complete verbal and paper communication process between hospice and her nursing staff, and there was not. The DON then said she was ultimately responsible for not following up with Hospice as she should have, and for the facility not having a clear process in place to obtain and scan resident's Hospice medical records timely into their electronic medical record. An interview was conducted on interview with Medical Records on 06/13/24 at 10:10 AM. Medical Records confirmed Resident #48 was under Hospice care since 05/03/24. Medical Records stated she had not received: a resident hospice comprehensive care plan, hospice admission documentation, and hospice physician's order for hospice services. She indicated these documents should have been provided by the Hospice and were not. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/13/24 at 10:24 AM with Hospice Nurse #12. She stated Resident #48 was visited by her weekly. She said she kept all her documentation on her electronic-pad and when she left, she did not provide copies of the notes to the nursing staff but gave a verbal report to a nursing staff member. She said she had visited the facility the day before and did not know the nurse she verbally reported off to. Hospice Nurse #12 did not know what happened to her verbal report information once the facility nurse left her shift. She said the resident was being well cared for by her and the facility's nursing staff. Hospice Nurse #12 revealed that not all Hospice documentation had been provided to the facility to scan into their electronic medical record. She said it was her expectation that Resident #48's complete Hospice medical records be available to facility staff. An interview on 06/14/24 at 10:20 AM with the facility Nurse Practitioner (NP) revealed that it was her expectation that Hospice provide to the facility all the Hospice documentation timely, which was not being done. The NP stated it was important to her and the attending physician to know what Hospice physicians were ordering and what their nursing staff were doing, so that Hospice and facility staff were communicating well and following the same plan of care, which had not happened in this case. An interview was conducted on 06/13/24 at 10:50 AM with the Administrator. She said it was her expectation that Resident #48's complete Hospice medical records be available to facility staff.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Deficiency Text Not Available

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37673 Based on record review, observation, and staff interviews, the facility failed to implement their policy for enhanced barrier precautions and hand hygiene during wound care for 1 of 3 residents (Resident #66) whose wound care was observed. The facility also failed to implement an infection surveillance plan for monitoring and tracking infections in the facility to help prevent the development and transmission of communicable diseases and infections. This deficient practice had the potential to affect 70 of 70 residents in the facility. Findings included: 1. Review of the facility Enhanced Barrier Precautions policy documented enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include wound care (any skin opening requiring a dressing). EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE (Personal Protective Equipment) required. PPE is available outside the room. Review of the facility Handwashing/Hand Hygiene policy documented the facility considered hand hygiene the primary means to prevent the spread of healthcare associated infections. Hand hygiene is indicated: immediately before touching a resident, before performing an aseptic task such as placing an indwelling device or handling an invasive medical device, after contact with blood, body fluids or contaminated surfaces, after touching a resident, after touching the resident ' s environment, before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene. On 06/14/24 at 10:00 am an observation of the Enhanced Barrier Precautions sign posted on Resident #66's door instructed staff to clean hands before entering and after leaving the room and to wear gloves and a gown for high contact resident care activities including wound care or any skin opening requiring a dressing. A supply of gowns and gloves were located in a bin in the hallway next to the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of wound care was made on 06/14/24 at 10:12 AM. Present were the Treatment Nurse and the Wound Care Specialist physician. The physician and the nurse donned gloves and gowns prior to entering the room. The physician partially removed the dressing and measured the Stage 4 coccyx pressure ulcer. Both the physician and the nurse removed their gloves and gowns and discarded them in an acceptable receptacle. In the hallway the physician and the nurse used alcohol based hand rub (ABHR). The physician directed the nurse to change the treatment to a new debriding ointment and a border dressing daily. The Treatment Nurse obtained the new ointment from the treatment cart and entered the room without donning a gown. She donned gloves and removed the old dressing and discarded it in an appropriate receptacle. The nurse discarded her gloves and donned new gloves before applying the new treatment. She did not wash her hands or use ABHR after she discarded her gloves or before moving to a clean body site on the same resident. In an interview with the Treatment Nurse after the dressing change on 06/14/24 at 10:30 am she stated she changed her gloves between removing the old dressing and applying the new dressing and she thought that was adequate. She stated she did not think she had to wash her hands if she changed her gloves. She acknowledged she had forgotten to wear a gown prior to reentering the room to complete the dressing change and stated she should have put one on. In an interview with the Infection Preventionist on 06/14/24 at 1:30 PM she stated the Treatment Nurse should have worn a gown during wound care and performed hand hygiene between removing the old dressing and applying the new dressing. In an interview with the Agency Director of Nursing on 6/14/24 at 4:30 PM she stated she expected staff to wear the appropriate PPE when treating residents on enhanced barrier precautions and perform hand hygiene when indicated. 49502 2. The facility's Infection Prevention and Control Program policy dated 4/1/24 stated the Infection Preventionist (IP) was responsible for completing surveillance of healthcare associated infections, tracking outbreaks and monitoring standard and transmission precautions. During a meeting with the Infection Preventionist (IP) on 6/14/24 at 3:49 pm she stated she started this position on 5/06/24 and was still in orientation. She was unable to provide any documentation of tracking or surveillance of infections, infection risks for the facility from May 2023 through May 2024. The IP provided a binder with monthly computer printouts of infections in the facility from January 2024 through June 18, 2024. During an interview with the Director of Nursing (DON) on 6/12/24 at 11:00 am she stated she began her position as DON on 3/25/24 and was not responsible for infection control. An interview with the Administrator on 6/14/24 at 4:00 pm revealed she had been the Administrator since 2/02/24 and was Statewide Program for Infection and Epidemiology (SPICE) certified. The Administrator stated the IP had not been monitoring or tracking the infections within the facility. She indicated she was helping the IP who was trying to get infection control in order. The Administrator further stated the facility should have been monitoring and tracking infections.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 41387 Based on record review and staff interviews, the facility failed to ensure all staff received training on dementia care, infection control policies and procedures and the elements of the Quality Assurance Performance Improvement (QAPI) program. This practice had the potential to affect all residents. Findings included: A review of the 2023 and 2024 annual education records from April 2023 to May 2024 provided by the facility revealed no documented evidence that dementia care, infection control training on policies and procedures and QAPI training were conducted for the staff. a. Medication Aide #5's personnel file was reviewed and revealed a date of hire of 11/8/2019. There was no documentation of dementia care, infection control and QAPI training in the personnel file. A phone interview was conducted on 7/1/2024 at 1:23 pm with Medication Aide #5. During the interview, Medication Aide #5 stated she was not able to recall having QAPI training since April 2023 and thought she had received some training on infection control and dementia care in the last year but was unable to recall for certain. b. Nurse Aide (NA) #2's personnel file was reviewed and revealed a date of hire of 8/13/2018. There was documentation NA# 2 had received dementia care training on 12/5/2023, and there was no documentation NA #2 had received infection control training on policies and procedures and QAPI training. A phone interview was conducted on 6/18/2024 at 5:49 pm with NA #2. She stated she felt like training as a whole had been overlooked with the all changes in the administrative team. She indicated she had received training on dementia care and QAPI training since changing roles as the activities director in 2024. She only recalled attending an in-service about not wearing gloves into the hallway as infection control training since April 2023. c. On 6/18/2024 at 06:14 pm in a phone interview with Nurse #8 who had worked at the facility the last two years, she stated she did not know what QAPI was. She said she had not received training while at the facility on QAPI or dementia care and had not received infection control training on policies and procedures since April 2023. d. On 6/19/2024 at 8:31 am in a phone interview with Medication Aide #3, she stated she had worked at the facility since 8/2023. When asked if she had received QAPI training,, Medication Aide #3 stated she did not know what QAPI was. Mediation Aide #3 further stated she had not received infection control training and did not recall receiving dementia care training since 8/2023. e. On 6/1/2024 at 7:56 am in a phone interview with Minimum Data Set (MDS) Nurse #4, she stated There had been no infection control and QAPI training since April 2023 and she was unable to recall receiving dementia care training. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/14/2024 at 4:11 pm in a phone interview with the Admissions Coordinator, she stated the facility did not have any evidence that infection control training and QAPI training was provided to all the staff at the facility. She explained when the previous Staff Development Coordinator (SDC) resigned, the SDC's office was cleaned and no one knew what happened to all the training documentation of all the staff at the facility. In a phone interview with the Director of Nursing (DON) on 6/19/24 at 10:22 am, she stated there was no Staff Development Coordinator (SDC) at the facility when she was hired in March 2024. The DON also stated she was unable to locate any files documenting dementia care, infection control training on policies and procedures and QAPI training to the staff since April 2023. She stated since there was no SDC, she was responsible for documenting the staff's training conducted by different administrative staff members, and stated since March 2024 she had not recorded any training hours and could not recall having training on dementia care, infection control and QAPI training. A phone interview was conducted on 6/19/24 at 12:25 P.M. with the Administrator. The Administrator explained when the SDC resigned two months ago, the SDC role was originally assigned to the new MDS Nurse #2 who was hired in April 2024. She explained MDS Nurse #2 was unable to manage the educational training due to learning the role as an MDS nurse and working on the back log of MDS assessments in the facility. She revealed MDS Nurse #2 had resigned during the state survey. She stated the facility currently did not have a Staff Development Coordinator and the responsibilities of the SDC for ensuring staff received the required annual training of dementia care, QAPI and infection control and documentation of the training fell ultimately to the DON to ensure completion. The Administrator explained there had been a high turnover in the DON position and felt the responsibility of scheduling dementia care, infection control and QAPI training for all the staff and tracking training had been overlooked.