STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Health & Rehab of Sylva	417 Cloverdale Road Sylva, NC 28779

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on observation, record reviews, an audio digital file, and interviews from resident, staff, and visitor, the facility failed to allow unrestricted visitation by limiting visitation for 1 of 1 resident reviewed for visitation (Resident #3). The findings included: Resident #3 was readmitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3's preferences included the following: It was very important to have family, or a close friend, involved in discussion about care. Review of Resident #3's quarterly MDS dated [DATE] indicated Resident #3 had severe cognitive impairment and required extensive assistance for most activities of daily living (ADL). An observation and interview with Resident #3 and Visitor #1 on 5/6/24 at 9:25 AM revealed Visitor #1 stated that Resident #3 became upset and expressed emotions through tears when she was notified that Social Worker #1 would not be able to visit any longer. Visitor #1 stated Resident #3 always looked forward to and enjoyed visits from Social Worker #1 when she visited after business hours or on weekends. Visitor #1 stated it would be Resident #3's wishes to have Social Worker #1 visit her. A telephone interview with Social Worker #1 on 4/30/24 at 10:57 AM revealed she was no longer employed at the facility but was the former Social Worker and had self-terminated her employment after approximately [AGE] years of service in the facility. Social Worker #1 stated she resigned from her employment around 4/5/24 and had continued to visit Resident #3 once to twice weekly during the month of April 2024. Social Worker #1 said she received a voicemail from the Administrator on 4/29/24 which indicated she would no longer be extended the luxury to visit and be on the facility premises because she was a self-terminated employee and that this notification would be followed up by a legal notice. (continued on next page)

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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the voicemail left on 4/30/24 (time unknown) on Social Worker #1's telephone by the facility Administrator revealed the following audible message: Hey [Social Worker #1] this is [Administrator] calling from [facility name]. Just wanted to touch base with you and let you know as far as visiting or being on the facility premises, we are not going to be able to extend that luxury to you. So, if you have any questions at all about what our policy is about self-termed employees are, please give me a call. We will be following this up with a legal notice to you in regard to this. If you have any questions, don't hesitate to give me a call. Alright, thank you. Bye. Bye. An interview with the Administrator on 5/7/24 at 9:45 AM revealed she had denied visitation to Resident #3. The Administrator stated she had left Social Worker #1 a voicemail regarding her being a self-terminated employee and her not being able to visit any longer because she felt it was best not to allow Social Worker #1 to return to the premises because if she allowed Social Worker #1 to visit then she would have to allow all other self-terminated employees to visit as well which she did not want to do at the time. The Administrator confirmed she had not spoken to Social Worker #1 since the voicemail had been left and stated she had written up a letter regarding Social Worker #1 not being allowed to visit and submitted it to the owner who had chosen for it not to be mailed to Social Worker #1. The Administrator said she had received no further updates regarding the visitation of Social Worker #1 to any resident in the facility from the owner.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 41069 Based on record reviews, and interviews with resident, staff and the Medical Director, the facility failed to notify a medical provider of significant changes in a resident's condition (Resident #8) who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 suspected drug overdose and administered one dose of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on [DATE] at 9:34 AM and an additional dose at 9:54 AM without notifying a medical provider. Resident #8 responded temporarily to the Narcan doses but at 3:50 PM, he was observed with no heart rate or respiratory rate and was pronounced dead. In addition, the facility failed to notify the Guardian after a resident (Resident #6) tested positive for tetrahydrocannabinol (THC - a compound found in cannabis/marijuana plants). This deficient practice affected 2 of 3 residents reviewed for notification of changes (Resident #8). Immediate jeopardy began on [DATE] when the facility failed to notify a medical provider of significant changes in Resident #8's condition suggestive of a possible drug overdose. The immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 is out of compliance at a level of D. The findings included: 1. Resident #8 was admitted to the facility on [DATE]. A progress note dated [DATE] at 9:36 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 was given Narcan per order. Oxygen saturation 68% (normal value 95% or higher), resident not responding to painful stimuli, pupils constricted. Narcan given in each nostril. Resident now 95% on oxygen. Blood pressure ,d+[DATE] (normal value less than ,d+[DATE]), heart rate 84 (normal value 60 to 100 beats per minute), respirations 18 (normal value 12 to 18 breaths per minute) and regular. Another progress note dated [DATE] at 9:47 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 now resting with eyes closed. Oxygen saturation 98%. No signs/symptoms of pain or shortness of breath. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with Nurse #14 on [DATE] at 10:56 AM revealed she was working as the weekend supervisor on [DATE] when Agency Nurse #20 alerted her. Nurse #20 told her that she had no idea what to do about Resident #8. When Nurse #14 came into Resident #8's room, he was very sweaty and was not responding. Resident #8 was sitting in his wheelchair at his bedside, and he was slumped over. Nurse #14 stated that she was afraid Resident #8 might fall forward off his wheelchair, so Nurse Aide (NA) #20 helped her put him back in bed. Nurse #14 stated that she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications he took by himself. Nurse #14 further stated after she gave Resident #8 the two doses of Narcan, he perked up. Nurse #14 said she thought Nurse #20 spoke with the on-call provider while she was busy taking care of Resident #8. Nurse #14 also stated that she did not think to call 911 because it seemed like the two doses of Narcan worked, and she noted on the physician's order that she could give another dose after 10 minutes if the first one did not work. After Nurse #14 administered the second dose, she observed that Resident #8's oxygen saturation was within normal limits, and he was talking to her although he said that he was tired and just wanted to lay there in the bed. Nurse #14 stated that Nurse #20 told her that she had called the doctor, and she thought that Nurse #20 had also called 911. Nurse #14 stated that she knew this was Nurse #20's first day working at the facility. A progress note dated [DATE] at 10:00 AM by Nurse #20 in Resident #8's medical record indicated: Resident #8 was sitting up in wheelchair, very difficult to arouse. Oxygen saturation was 71% on oxygen via nasal cannula. Resident #8 was placed back to bed with head of bed elevated. Somewhat more responsive but continued to nod off. Oxygen saturation increased to the low 80% with deep breaths. Narcan administered by Nurse #14. Narcan somewhat effective, more alert and verbal. Morning medications held. A second progress note dated [DATE] at 12:58 PM by Nurse #20 in Resident #8's medical record indicated: Resident #8 difficult to arouse at this time. Responds to sternal rub (application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) with mumbles. Oxygen on per order via nasal cannula. BiPAP (bilevel positive airway pressure which is a form of non-invasive ventilation therapy used to help you breathe) placed on. More verbal and alert at this time. A third progress note dated [DATE] at 3:50 PM by Nurse #20 in Resident #8's medical record indicated: Upon observation, no heart rate or respiratory rate noted. Responsible party aware. Nurse Practitioner aware, order to release body to the funeral home received and noted. Funeral home contacted per family request. A phone interview with Nurse #20 on [DATE] at 12:26 PM revealed NA #21 alerted her that Resident #8 was lethargic. When Nurse #20 checked Resident #8's oxygen saturation, it was dropping so she asked Nurse #14 for help. Resident #8 woke up somewhat after he received the two doses of Narcan. Nurse #20 explained that [DATE] was her very first day working at the facility as an agency nurse and she did not have access at the time to the clinical messaging platform that the facility used to contact the on-call providers. Nurse #20 stated that she did not think about calling the on-call provider because she thought that Nurse #14 took over Resident #8's care when she gave him the Narcan. Nurse #20 explained that during this incident, she was still trying to get her medication pass done, and she thought Nurse #14 was going to take care of Resident #8. Nurse #14 stated she did not recall telling Nurse #14 whether she called the provider or not because she thought Nurse #20 was going to do it. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with the former Social Worker (SW) on [DATE] at 12:45 PM revealed she was the manager on duty on [DATE]. The former SW stated that when she came in that morning around 9:30 AM, Nurse #14 told her that Resident #8's pupils were pinpoint, and that they needed help to put him back into bed. The former SW stated she observed Resident #8 slumped over in his wheelchair and she thought he was going to die right there. Resident #8's eyes were pinpoint, and she watched Nurse #14 give Resident #8 two doses of Narcan. The former SW further stated that she told Nurse #14 that the facility's policy was to immediately call EMS, call the doctor and send the resident to the hospital after the resident was given Narcan. The former SW stated that she told Nurse #14 to call EMS right after Nurse #14 administered the Narcan to Resident #8. A joint interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on [DATE] at 1:11 PM. The ADON stated that she did not know if Nurse #14 notified the provider, but said she would have called the doctor if she was at the facility. An interview with the Medical Director (MD) on [DATE] at 10:21 AM revealed he last saw Resident #8 on [DATE] when he visited him after he had just gotten back from the hospital for COPD and CHF, and he seemed to be doing fine during the visit. The MD stated that he was not notified when Resident #8 died but he found out about it the next day he visited the facility. The MD stated that he did not know that they administered Narcan to Resident #8, and he was not familiar with the facility policy for Narcan. The MD stated that if the policy indicated for staff to notify EMS when administering Narcan, then they should have followed that. The MD confirmed that low oxygen saturation and pupil constriction were signs of overdose, and that Resident #8 should have been sent out to the hospital on [DATE]. The MD added that if an on-call provider was notified about the Narcan doses, then there would be a note in Resident #8's chart and they would have ordered to send him out to the hospital. The Administrator was notified of immediate jeopardy on [DATE] at 2:50 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 notify the medical provider of the suspected drug overdose of Resident #8 who was observed unresponsive to painful stimuli, had low oxygen saturation, and pupil constriction, and received 2 doses of Narcan on [DATE] at 9:34 AM and 9:54 AM. The guidelines for notifying physicians of clinical problems to ensure 1) medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record was not followed in the administration to Resident #8 by Nurse #14. The facility notified the medical provider of the suspected drug overdose of Resident #8 who was observed unresponsive to painful stimuli, low oxygen saturation, and pupil constriction receiving 2 doses of Narcan on [DATE] at 9:34 AM and 9:54 AM on [DATE] by the Director of Nursing Services (DNS). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility look-back audit of 30 days was completed by the Nurse Consultant on [DATE] to ensure that for any resident that was administered Narcan, the medical provider was notified. The audit did not identify any other residents who were administered Narcan. An audit will be completed by [DATE] by the Nurse Consultant on the number of residents who use opioids, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids. The audit identified 3 residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician order. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The specific actions the facility will take to alter the system failure to prevent a serious outcome from reoccurring are: * Re-education to licensed nursing staff, including agency nurses on ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders by the Director of Nursing Services/Assistant Director of Nursing (designee) by [DATE]. Licensed nursing staff that are not available on or before [DATE] will not be scheduled until the education has been completed. * Facility wide audit completed by Nurse Consultant by [DATE] to determine if for any resident who received Narcan, the medical provider has been notified. The audit identified 3 residents who have a diagnosis of opioid dependence, one resident has scheduled pain management, and two residents have prn pain management per physician order. * The actions the facility will take to ensure the nurses notify the medical provider of administration of Narcan by the DNS reviewing the 24-hour report on a daily basis for appropriate notification documentation in the Electronic Medical Record (EMR). Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the Director of Nursing Services and/or the Assistant Director of Nursing Services, Unit Managers, and Supervisors. * If the Director of Nursing Services is unavailable the Assistant Director of Nursing will assume this responsibility of reviewing the 24-hour report. * Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose prior to working their first shift by the DNS/Assistant Director of Nursing (designee). The alleged date of immediate jeopardy removal is [DATE]. The credible allegation for the immediate jeopardy removal was validated on [DATE] with a removal date of [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of in-service education records dated [DATE] indicated education was provided to nurses including agency nurses on ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with the nursing staff including agency nurses revealed they had been educated on notifying the medical provider of any resident who receives Narcan for suspected overdose. The audit completed by the Nurse Consultant on [DATE] was reviewed. All residents identified as having orders for Narcan administration had notification of medical providers added to the Narcan order. The facility's date of immediate jeopardy removal of [DATE] was validated. 36217 2. Resident #6 was admitted to the facility on [DATE]. The nurse's progress notes dated [DATE] revealed Resident #6 was found to have slurred speech and unable to sit, stand, or keep his eyes opened at around 8:45 PM. He could not answer questions from the staff but was making the comment I feel good and high. Around 9:00 PM, a urine specimen was obtained per the on-call provider's order for a drug screening. On [DATE] at 1:30 AM, the results from the urine drug screening were obtained and faxed to the on-call provider. A review of medical records indicated Resident #6 had a 12-Panel urine drug screening conducted on [DATE] and was positive for THC. A review of medication administration records (MARs) from [DATE] through [DATE] revealed Resident #6 was not ordered to receive any medications containing THC. During an interview conducted on [DATE] at 3:30 PM, Resident #6 stated he would not take drugs from anyone except nurses in the facility. He attributed the incident to the medications he received from the nurses in the facility prior to the incident. A phone interview was conducted with Nurse #2 on [DATE] at 4:15 PM. She stated she worked second shift from 7 PM to 7 AM on [DATE] evening and was providing care for Resident #6 in 300 Hall. At around 8:45 PM, Resident #6 was brought to her by a staff member from the rehab department with altered mental status, impaired movements, and slurred speech. She contacted the on-call provider immediately and was told to monitor Resident #6's vital signs and collect urine specimen for a drug screening. After obtaining Resident #6's urine specimen, she ordered one of her nurse aides (NA) to bring it to the local hospital immediately and waited for the results. At around 1:30 AM, the results from the urine drug screening confirmed Resident #6 was positive for THC. She faxed the results to the on-call provider immediately and was ordered to report the results to the Director of Nursing (DON). She did not notify Resident #6's Guardian after she received the drug screening results as it was late and non-urgent. She explained after she notified DON and Unit Manager (UM) #2 in the morning, she assumed either one of them would notify the Guardian. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview conducted on [DATE] at 10:30 AM, Resident #6's Guardian stated he did not know that Resident #6 was tested positive for THC on [DATE] morning and confirmed none of the staff in the facility had notified him about the drug screening results after the incident. It was his expectation for the facility to notify him within 24 hours after the incident occurred. During an interview conducted on [DATE] at 11:52 AM, UM #2 stated Nurse #2 reported the incident to her on [DATE] in the morning. However, she did not specifically ask her to notify Resident #6's Guardian before leaving for the shift, and she assumed the notification had been made. An interview was conducted with the DON on [DATE] at 12:54 PM. She stated the hall nurse (Nurse #2) was responsible for notifying the Guardian after Resident #6 was tested positive for THC. The UM would be the back-up if the hall nurse was unable to do it. It was her expectation for the hall nurse and the UM to communicate with each other to ensure the Guardian was notified as soon as possible. An interview was conducted with the MD on [DATE] at 1:53 PM. He stated he was being notified of the incident on [DATE] in the morning and expected the Guardian to be notified in a timely manner as well. During an interview conducted on [DATE] at 3:28 PM, the Administrator stated it was her expectation for the facility to notify Resident #6's Guardian regarding the incident in a timely manner.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on observations and staff interviews the facility failed to maintain clean and sanitary floors (bathroom of room [ROOM NUMBER], 208, 301 rooms 310, 301, 303, 211), maintain clean and sanitary privacy curtains (rooms [ROOM NUMBERS]), ensure a baseboard was clean and sanitary (room [ROOM NUMBER]), ensure the toilet was clean and in good repair (room [ROOM NUMBER]), ensure a bathroom was free of lingering odors (room [ROOM NUMBER]), and maintain baseboards in good repair (bathroom of 303 and 114) for 3 of 4 halls (100 hall, 200 hall, and 300 hall) reviewed for safe, clean, and homelike environment. The findings included: 1. (a). An observation of the shared bathroom floor of room [ROOM NUMBER] on 05/07/24 at 10:35 AM revealed dried yellow and brown stains scattered across the entire floor. Additional observations of the shared bathroom floor of room [ROOM NUMBER] on 05/10/24 at 8:57 AM revealed dried yellow and brown stains scattered across the entire floor. (b). An observation of the bathroom floor of room [ROOM NUMBER] on 05/07/24 at 10:43 AM revealed multiple areas of dried brown/black stains scattered across the floor. Additional observations of the bathroom floor of room [ROOM NUMBER] on 05/08/24 at 8:58 AM and 05/10/24 at 8:23 AM revealed multiple areas of dried brown/black stains scattered across the floor. (c). An observation of the floor of room [ROOM NUMBER] on 05/07/24 at 11:15 AM revealed scattered food debris across the entire floor. Additional observations of the floor of room [ROOM NUMBER] on 05/07/24 at 3:34 PM and 05/08/24 at 9:03 AM revealed scattered food debris across the entire floor. (d). An observation of the floor of room [ROOM NUMBER]-B on 05/07/24 at 11:20 AM revealed the floor was covered with food debris. An observation of the bathroom floor of room [ROOM NUMBER] at the same date and time revealed multiple areas of dried yellow/brown stains across the entire floor and a wad of brown hair was lying on the floor. Additional observations of the floor and bathroom floor of room [ROOM NUMBER] on 05/10/24 at 9:05 AM revealed the entire room floor was covered with food debris and the bathroom floor had multiple areas of dried yellow/brown stains across the entire floor and a wad of brown hair was lying on the floor. (e). An observation of the floor of room [ROOM NUMBER] on 05/08/24 at 9:06 AM revealed scattered food debris across the entire floor. (f). An observation of the floor of room [ROOM NUMBER] on 05/10/24 at 8:55 AM revealed food debris to the entire floor. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview with Housekeeper #1 on 05/10/24 at 11:50 AM revealed she worked 9:00 AM to 2:00 PM. She stated her assignment on 05/10/24 was 300 hall and 400 hall, any offices upstairs, and the therapy room. Housekeeper #1 stated cleaning each resident room consisted of collecting trash, sweeping and mopping the floors in the rooms and bathrooms, cleaning the sink and toilet, and cleaning baseboards if they appeared dirty. She stated there were days when she was unable to clean all of her assigned rooms before her shift ended and she notified her supervisor if she was unable to finish her assignment. An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated routine cleaning of resident rooms included disinfecting all flat surfaces, sweeping and mopping the floor and bathroom floor, cleaning the bathroom sink, toilet, shower, and removing the trash. The Housekeeping Director stated all resident rooms were to be cleaned in the morning if possible and then a second should be performed to see if the rooms needed further attention. She stated she had been short on housekeeping staff, but she rounded on resident rooms to check for concerns and management staff also had a group of rooms they were assigned to check and notify her of any housekeeping concerns. The Housekeeping Director stated she expected bathrooms and resident rooms to be clean. 2. (a) An observation of the privacy curtain between beds in room [ROOM NUMBER] on 05/07/24 at 10:56 AM revealed a large, dried brown/purple stain approximately halfway up the curtain. Additional observations of the privacy curtain between beds in room [ROOM NUMBER] on 05/07/24 at 3:23 PM, on 05/08/24 at 8:27 AM, on 05/08/24 at 12:28 PM, and on 05/10/24 at 8:50 AM revealed a large, dried brown/purple stain approximately halfway up the curtain. (b). An observation of the privacy curtain closest to the door of room [ROOM NUMBER] on 05/10/24 at 8:55 AM revealed scattered dried brown stains. An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated she changed room divider curtains monthly and were also checked by housekeeping daily. The Housekeeping Director stated she also changed room divider curtains when she was notified of any concerns, and she was not aware of any concerns with the curtains in rooms [ROOM NUMBERS]. She stated she expected room curtains to be clean and free of stains. 3. An observation of the baseboard of room [ROOM NUMBER]-B to the left of the bed on 05/07/24 at 10:43 AM revealed a dried dark brown stain. Additional observations of the baseboard of room [ROOM NUMBER]-B to the left of the bed on 05/08/24 at 8:58 AM and 05/10/24 at 8:23 AM revealed a dried dark brown stain. An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated housekeeping staff should clean baseboards when they were visibly soiled and when rooms were deep cleaned. The Housekeeping Director stated she had been short of staff, but she had just hired a new housekeeper and was hoping that would make her available to do more deep cleaning of resident rooms. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Health & Rehab of Sylva	417 Cloverdale Road Sylva, NC 28779

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	4. An observation of the bathroom of room [ROOM NUMBER] on 05/07/24 at 10:38 AM revealed the entire area around the base of the toilet had yellow and brown stains and a strong odor of urine was noted. Additional observations of the bathroom of room [ROOM NUMBER] on 05/08/24 at 8:54 AM and on 05/10/24 at 8:58 AM revealed the entire area around the base of the toilet had yellow and brown stains and a strong odor of urine was noted. An interview with the Maintenance Director on 05/10/24 at 11:10 AM revealed he checked 4 to 5 random rooms each week for any maintenance issues that may need to be addressed. He stated management staff are assigned a group of rooms they check Monday through Friday and were supposed to notify him of any maintenance concerns. The Maintenance Director stated work order forms were available in a folder outside his door and could be completed and slid under his door and he also accepted verbal work order requests from staff. He stated he was not aware of any concerns with the caulking around the toilet in room [ROOM NUMBER]. An interview and walking round were conducted with the Housekeeping Director on 05/10/24 at 1:00 PM. She stated resident bathrooms were to be cleaned daily and should be free of odors. 5. (a) An observation of the bathroom of room [ROOM NUMBER] on 05/08/24 at 9:06 AM revealed the baseboard behind the toilet was pulling away from the wall. An additional observation of the bathroom of room [ROOM NUMBER] on 05/10/24 at 10:50 AM revealed the baseboard behind the toilet was pulling away from the wall. (b). An observation of the bathroom of room [ROOM NUMBER] on 05/10/23 at 9:03 AM revealed the baseboard behind the toilet was pulling away from the wall. An interview with the Maintenance Director on 05/10/24 at 11:10 AM revealed he checked 4 to 5 random rooms each week for any maintenance issues that may need to be addressed. He stated management staff are assigned a group of rooms they check Monday through Friday and were supposed to notify him of any maintenance concerns. The Maintenance Director stated work order forms were available in a folder outside his door and could be completed and slid under his door and he also accepted verbal work order requests from staff. He stated he was not aware of any concerns with the baseboards in the bathrooms of 303 and 114. The Maintenance Director stated he expected all baseboards to be in good repair. An interview with the Administrator on 05/10/24 at 4:15 PM revealed the maintenance and housekeeping departments had corrected a number of environmental issues over the past few months and still had a number of projects they were planning to address. She stated she expected resident rooms and bathrooms to be clean and free of odor, privacy curtains to be free of stains, and baseboards to be in good repair.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 41069 Based on record reviews, and interviews with staff and the Medical Director, the facility failed to protect a resident's right to be free from neglect when they failed to provide care and services to a resident experiencing a medical emergency. The facility failed to activate emergency response for Resident #8 who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 administered two doses of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on [DATE] at 9:34 AM and 9:54 AM, with positive response, for suspicion of drug overdose. At 3:50 PM, Resident #8 was observed with no heart rate or respiratory rate and was pronounced dead. In addtion, on [DATE] the facility neglected to provide incontinence care to Resident #8 who was cognitively intact but experienced mental status changes with new onset of hallucination and confusion and required increased assistance with toileting. Resident #8 had a fall on [DATE] while attempting to go to the bathroom without assistance. Resident #8 was hospitalized with a left hip fracture requiring surgical repair and a four centimeter laceration to the left upper extremity which required two-layer suture repair. This deficient practice affected 1 of 4 residents reviewed for abuse and neglect (Resident #8). Immediate jeopardy began on [DATE] when staff found Resident #8 slumped over, non-responsive with constricted pupils and impaired respiration and administered two doses of Narcan for suspected drug overdose, was not provided emergency medical services, and subsequently died . Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. Example #2 is out of compliance at a level of G. The findings included: 1. The first example for this tag is cross-referred to: F580 - Based on record reviews, and interviews with resident, staff and the Medical Director, the facility failed to notify a medical provider of significant changes in a resident's condition (Resident #8) who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 suspected drug overdose and administered one dose of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on [DATE] at 9:34 AM and an additional dose at 9:54 AM without notifying a medical provider. Resident #8 responded temporarily to the Narcan doses but at 3:50 PM, he was observed with no heart rate or respiratory rate and was pronounced dead. In addition, the facility failed to notify the Guardian after a resident (Resident #6) tested positive for tetrahydrocannabinol (THC - a compound found in cannabis/marijuana plants). This deficient practice affected 2 of 3 residents reviewed for notification of changes. F684 - Based on record reviews, and interviews with staff and the Medical Director, the facility failed to initiate emergency medical services for symptoms of a drug overdose. Resident #8 was slumped over, non-responsive with constricted pupils and impaired respiration. Resident #8 was observed by a facility staff member with no heart rate or respiratory rate and was pronounced dead on [DATE] at 3:50 PM. This deficient practice affected 1 of 3 residents reviewed for quality of care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F726 - Based on record reviews, and staff interviews, the facility failed to ensure nursing staff were trained and competent with responding to medical emergencies, activating emergency procedures with emergency medical services, and notifying medical providers for 1 of 4 residents (Resident #8) reviewed for neglect. Nursing staff failed to notify a medical provider of significant changes in a resident's condition who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction, and failed to immediately initiate emergency procedures with 911. Resident #8 expired on [DATE]. This was for 2 of 2 staff members reviewed for competency (Nurse #20 and Nurse #14). The Administrator was notified of immediate jeopardy on [DATE] at 10:37 AM. 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 neglected to activate emergency response for Resident #8 after Nurse #14 administered Narcan on [DATE] at 9:34 [NAME], again at 9:54 AM with positive response for suspicion of drug overdose. In addition, the nurse supervisor did not activate emergency response. All residents who use opioid medications are at risk of overdose and may be subject to the need for Narcan administration and emergency response. An audit will be completed by [DATE] by the Nurse Consultant on the number of residents who are prescribed opioid medication, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The specific actions the facility will take to alter the system failure to prevent a serious outcome from reoccurring are: * The licensed nursing staff who neglected to activate emergency response were Nurse #14 and Nurse #20. * The facility has filed a report of the neglect to the health care personnel registry on [DATE]. * Education on the facility policy for Abuse and Neglect Prevention was presented to all facility staff beginning [DATE] by the Administrator, Director of Nursing and Assistant Director of Nursing. This educational in-service included the policy and implementation of procedures to prevent abuse and neglect. Included in this education was a review of staff training expectations on preventing, identifying, reporting abuse and neglect. * The facility has filed a report of the neglect to the licensing agency on [DATE]. * The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The actions the facility will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers. * Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee). * The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system which is denoted in the revised Narcan Administration Policy [DATE]. The alleged date of immediate jeopardy removal is [DATE]. The credible allegation for the immediate jeopardy removal was validated on [DATE] with a removal date of [DATE]. A review of in-service education records dated [DATE] to [DATE] indicated education was provided to all facility staff including contract staff on the policy for Abuse and Neglect Prevention which included staff training expectations on preventing, identifying, and reporting abuse and neglect. Education was also provided to nurses including agency nurses on the activation of emergency response upon administration of Narcan, and ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with staff revealed they had been educated on the facility policy for preventing abuse and neglect. Interviews with the nursing staff including agency nurses revealed they had been educated on activating EMS and notifying the medical provider of any resident who receives Narcan for suspected overdose. The nurses including agency nurses stated they received education on medical emergencies and activation of the emergency response. A review of the revised Narcan administration policy dated [DATE] indicated the nurse who responds to the suspected overdose will direct another staff member to activate EMS. The facility's date of immediate jeopardy removal of [DATE] was validated. 42090 2. Resident #8 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease (COPD), acute respiratory failure, shortness of breath and anxiety. A review of Resident #8's comprehensive care plan revealed an activities of daily living plan of care dated [DATE] which included the following interventions: - The resident requires assistance by staff with personal hygiene. - The resident requires assistance by staff with toileting. - The resident requires assistance by staff to move between surfaces. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact and was independent for transfers and hygiene. The assessment indicated Resident #8 was independent and continent of bowel and bladder, had no behaviors or rejection of care. A review of Resident #8's physician's order revealed the following: - [DATE] consult for Hospice services for end stage COPD. - [DATE] Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 0.4 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation. - [DATE] Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 0.5 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation. - [DATE] Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 0.75 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation. - [DATE] Morphine Sulfate (concentrate) 20 mg (milligrams)/ mL (milliliter)- administer 1.0 ml every 2 hours for pain or shortness of breath (SOB); hold if sedation. A nurse progress note written on [DATE] at 4:00 AM by Nurse #2 read as follows: Resident is noted to be very busy. He is constantly messing with anything in reach. Objects have been removed for his safety. He is not keeping his O2 (oxygen) in place. Easily anxious with neb (nebulizer) treatments and removes from face. Needs supervision to maintain his O2 placement. Not wanting to take scheduled and routine meds but then easily upset if meds are not given. See MARS (medication administration records) for med administration. Hallucinations off and on. Asking to wear a brief (adult incontinence product) to assist with no movement due to exertion and SOB (shortness of breath). Drinking well. Frequent rounds made. Resident will use call bell at times then he yells out! Call bell is in reach. An interview with Nurse #2 on [DATE] at 4:54 PM revealed she was assigned to care for Resident #8 on night shift from 7:00 PM on [DATE] until 7:00 AM on [DATE]. Nurse #2 indicated Resident #8 was very anxious on that night and she recalled him hallucinating which she assessed to be related to his recent increase in opioid medications. Nurse #2 said although Resident #8 was at baseline continent of bowel and bladder and independent to supervision assistance with toileting, he was more confused that night and staff had convinced him to wear a brief to help him with comfort and to conserve his exertion of him having to get up and down from the bed causing him increase shortness of breath. Nurse #2 stated Resident #8 remained anxious during her shift and she reported these changes to the oncoming nurse at 7:00 AM who she believed to be Nurse #3. A nurse progress note written on [DATE] at 11:47 AM by Nurse #3 read as follows: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Res (Resident) is up on side of bed unable to eat lunch due to confusion as well as hallucinations res had a hard time this am with taking breathing treatments writer had to sit with res and hold res hand as well as hold the mask to talk with res due to res felt as if the breathing treatment was suffocating res. Res is crying and tearful due to seeing cats and cars, Res is also wearing a brief at this time due to decline in health status res has made a choice to be comfort measures staff have checked in on resident multiple times this shift. Res is digging through draws (drawers) and making room in disarray as staff walk in throughout checks res is unsure of what he is doing res has had one dose of Morphine (opioid medication used to control pain and aid in breathing during air hunger) this shift as well as morning medications. Staff will continue to check on resident throughout shift. An additional progress note written on [DATE] at 4:43 PM by Nurse #3 read as follows: Res was noted to be laying on the bedroom floor res has a gash noted to the left upper arm res also has pain and discomfort noted to the left hip and femur res is unable to move leg or hip area res is in pain and discomfort res on call provider is notified as well as POA (power of attorney) is notified res is sent to ER (emergency room) for treatment and evaluation at this time. DON (Director of Nursing) is notified for the fall. A review of Resident#8's hospital emergency room report dated [DATE] indicated Resident #8 arrived at the hospital via ambulance status post an unwitnessed fall with complaints of pain to his left hip. Resident #8 was comfort care with some confusion noted but expressed desire to have his hip fixed due to worsening pain when he moved. The report includes a radiological report from a left hip and pelvis x-ray which resulted in a foreshortened subcapital left femoral neck fracture (most common fracture in the elderly population where the fracture line extends through the junction of the head and neck of the femur) and 4 cm (centimeter) laceration to his left upper arm which required 2 layered repair with sutures. The ER report further detailed he had an increase in lethargy (sluggish) and hypoxia (low levels of oxygen in the blood) in the emergency department and as a result was admitted to the intensive care unit. Resident #8 was readmitted to the facility on [DATE] with diagnoses that included an unspecified intracapsular left hip fracture and chronic respiratory failure with hypoxia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Nurse #3 on [DATE] at 12:19 PM revealed she was assigned to care for Resident #8 on day shift on [DATE] from 7:00 AM to 7:00 PM. Nurse #3 indicated she recalled Resident #8 being very agitated and anxious in the first portion of the shift. Nurse #3 said staff had convinced him to allow assistance to get back in the bed and allow assistance for incontinence by use of wearing a brief to decrease exertion from increase movement and fidgeting. Nurse #3 said she provided him with his medications during the shift but had not provided any incontinence care during her shift. Nurse #3 stated Nurse Aide #18 was assigned to Resident #8 and would have provided him with incontinence care. Nurse #3 said she was standing at her medication cart sometime after her afternoon medication pass was completed and was alerted by Resident #6 (Resident #8's roommate) that she needed to come to the room because Resident #8 had fallen to the floor. Nurse #3 explained she rushed down to Resident #8's room to find him lying on the floor on his side and face facing towards the floor, a heavily soiled brief located around his knees and lying in a puddle of urine. Nurse #3 said he had multiple cuts and gashes on his body, and he was complaining of severe pain in his left hip. Nurse #3 said she recognized the hip was fractured and immediately initiated calling the emergency medical services [DATE] line for transport for evaluation and treatment. Nurse #3 stated she sent Resident #8 to the hospital; she was not aware NA #18 had not provided him with incontinence care and she had not assigned his care to another nurse aide on the unit. An interview with Nurse Aide (NA) #18 on [DATE] at 3:38 PM revealed she was assigned to Resident #8 on [DATE] during day shift (7:00 AM to 7:00 PM). NA #18 stated she had gone in to see Resident #18 at approximately 9:00 AM for incontinence care. NA #18 indicated during that care, Resident #8 became very upset and had threatened her to say he would beat her a**. NA #18 said after completing the incontinence care she left the room and told Nurse #3 about the interaction and that she had concerns about providing him with further care. NA #18 stated Nurse #3 gently reminded her that the behaviors Resident #8 was currently exhibiting were not his morning baseline and if he were himself, he would apologize for what he said that he didn't mean any of it. NA #18 indicated this had not reassured her since his threat had caused her to have flashbacks from personal traumas of her past and therefore, she did not provide any further incontinence care to Resident #8 that day. NA #18 stated she periodically stepped in the room to verify that he was breathing until she was called to his room by Nurse #3 stating he had fallen, and she needed assistance. NA #18 said when she arrived at Resident #18's doorway, she saw Resident #8 on the floor with blood on him and the floor, his soiled brief halfway down his legs around his knees and laying in a puddle of urine with his wheelchair resting upon him. NA #18 said this made her feel guilty that she had not provided him with incontinence care, and he had attempted to go by himself as a result. NA #18 said she did not tell Nurse #3 at the time she had not provided him with incontinence care after 9:00 AM that morning. An interview with Nurse Aide (NA) #20 on [DATE] at 9:22 AM revealed that he was not assigned to Resident #8 on that morning ([DATE]) but had gone in to provide him his breakfast tray about 8:00 AM and retrieved a pitcher of tea, a pitcher of water, and a pitcher of ice for Resident #8 upon request at the time of the breakfast delivery. NA #20 said he did not return to Resident #8's room until he was summoned by Nurse #3 shortly after 4:00 PM that afternoon when he was alerted that Resident #8 had fallen. NA #20 indicated he approached Resident #8's room to find him lying on the floor on his side with his brief which was visibly saturated located around his knees and a puddle of urine surrounding him on the floor. NA #20 said Resident #8 was complaining of terrible pain and after initial assessment was sent to the emergency room for evaluation. NA #20 said he was not asked to provide assistance with incontinence care to Resident #8 on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Director of Nursing on [DATE] at 12:03 PM revealed she had not been aware NA #18 had not provided incontinence care to Resident #8 on [DATE] from 9:00 AM until he fell around 4:00 PM. The DON stated incontinence care should be provided to Resident #8.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and staff interviews, the facility failed to report suspicious white powder and a pill splitter (device used to cut a pill in half) found in Resident #8's room to local law enforcement after Resident #8 was suspected of drug overdose and was given two doses of Naloxone, also known as Narcan (a medication designed to rapidly reverse opioid overdose in an emergency situation) with positive response. The facility also failed to investigate and preserve potential evidence when they lost the white powder. In addition, the facility failed to submit a complete investigation report and notify Adult Protective Services after Resident #7 alleged abuse from a staff member. This deficient practice affected 2 of 4 residents reviewed for abuse and neglect (Resident #8 and Resident #7). The findings included: 1. The facility's policy Abuse Investigations, dated 2017 indicated all reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The facility's policy Reporting Abuse to State Agencies and Other Entities/Individuals, dated 2017 indicated: Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident, including law enforcement officials. Resident #8 was admitted to the facility on [DATE]. A review of Resident #8's Medication Administration Record for [DATE] indicated he received Naloxone liquid 4 milligrams (mg) in nostril on [DATE] at 9:34 AM and 9:54 AM. This medication was documented as given by Nurse #14. A phone interview with Nurse #14 on [DATE] at 10:56 AM revealed she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications. Nurse #14 stated she gave Resident #8 the two doses of Narcan which perked him up. After Nurse #14 administered the second dose, she observed that Resident #8's oxygen saturation was within normal limits, and he was talking to her although he said that he was tired and just wanted to lay there in the bed. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview with the former Social Worker (SW) on [DATE] at 12:45 PM revealed she worked as the manager on duty on [DATE] when Resident #8 died . The former SW stated she observed Resident #8 slumped over in his wheelchair and she thought he was going to die right there. Resident #8's eyes were pinpoint, and she watched Nurse #14 give Resident #8 two doses of Narcan. The former SW claimed that nobody took it seriously when Resident #8 died because on the evening after he died , staff found a pill splitter with white powder in his drawer when they cleaned his room. The former SW stated this was discussed during the morning meeting on [DATE] in which the Administrator was present. The former SW stated that they had been suspecting Resident #8 to be doing drugs because he sometimes acted like he was impaired and was on some other medications not prescribed for him. The former SW shared that she brought this concern to the attention of the Administrator, but she was told that it was just an assumption, and no investigation was done. A phone interview with Nurse Aide (NA) #3 on [DATE] at 4:05 PM revealed she was in Resident #8's room with NA #22 on the evening of [DATE] after Resident #8 died . NA #22 found a pill splitter that had a build-up of white powder. NA #3 stated that the white powder looked like remnants from pills being crushed or cut on the pill splitter. NA #3 stated that they stopped what they were doing and turned in the pill splitter with white powder to Nurse #2 who placed it in a reusable plastic bag. NA #3 stated that she and NA #22 searched Resident #8's entire room because they were worried about him having taken medications that were not given to him by the nurse. NA #3 explained that Resident #8 had been caught with vapes in his room in the past and had medication-seeking behaviors. NA #3 shared that after searching Resident #8's whole room, they did not find anything else. A phone interview with NA #22 on [DATE] at 6:52 PM revealed that on the evening when Resident #8 died , she and NA #3 cleaned out his room and found a pill splitter with white powder in the third drawer of his dresser. NA #22 stated that she immediately turned it over to Nurse #2 who locked it in the medication room to give to Nurse #14 who was the weekend supervisor the next day. A phone interview with Nurse #2 on [DATE] at 4:54 PM revealed on [DATE] after Resident #8 died , NA #3 and NA #22 brought her a pill splitter with white powder residue on it to the nurses' station. Nurse #2 stated that the nurse aides found it in Resident #8's dresser. Nurse #2 said that she placed both items in a reusable plastic bag along with a note and gave it to Nurse #14, but nothing was done about it. During an interview with Nurse #14 on [DATE] at 8:32 AM, she shared text messages from the nursing leadership chat between the Administrative nursing team consisting of the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the two Unit Managers, and Nurse #14. Nurse #14 stated she reported through the group chat on the morning of [DATE] that a pill splitter was found in Resident #8's belongings. The ADON responded with a text message on [DATE] at 10:43 AM: if a pill splitter was found, I don't know how or why. Nurse #14 stated that the pill splitter and the white powder were in two separate plastic bags. She further stated that there was quite a bit of white powder in the bag, and it was enough to fill up about one centimeter from the bottom of the plastic bag. Nurse #14 said she put both bags in the former Social Worker's box which was located in the conference room because her office was locked that day, and she couldn't get in it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up phone interview with the former SW on [DATE] at 11:18 AM revealed Nurse #14 did not put the pill splitter and white powder found in Resident #8's room in her box. The former SW stated that did not even make sense because she was in the building at that time, and if Nurse #14 wanted to hand it to her, she would have given it to her directly. The former SW stated that she never laid her eyes on the pill splitter and the white powder, and if she did, she would have immediately reported it to the Administrator and she would have done something about it. A phone interview with Nurse #21 on [DATE] at 11:10 AM revealed she used to be a Unit Manager and she found out about the pill splitter with white powder during the morning meeting on the Monday after Resident #8 died . Nurse #21 stated she couldn't remember if it was given to the former SW, the DON or the ADON, and she did not know if it was disposed of. Nurse #21 stated that the Administrator was present in the morning meeting on [DATE]. She did not remember the police being notified about the pill splitter and white powder. During a joint interview with the DON and the ADON on [DATE] at 3:29 PM, the ADON stated that she became aware about the pill splitter with white powder on [DATE], and she was sure it was talked about in the morning meeting on [DATE] with the Administrator present. The ADON stated it was out of her hands, and as far as she knew, it was handled between the former SW and the Administrator. During a phone interview with the Administrator on [DATE] at 11:55 AM, she initially stated that she was not aware that Resident #8 had passed away until the Monday when she came in to work. The Administrator stated that she was not aware of staff finding a pill splitter with white powder and that this was the first time she had heard about it. The Administrator further stated that she did not know that Resident #8 had his own pill splitter in the room and that she would have to look back and see if she had attended the morning meeting on [DATE]. 2. The facility's policy Reporting Abuse to State Agencies and Other Entities/Individuals, dated 2017 indicated: Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident, including Adult Protective Services (APS). Resident #7 was admitted to the facility on [DATE]. The Incident/Investigation Report by the local county sheriff's office dated [DATE] which was not included in the facility's investigation report indicated a text message from Resident #7 to the Unit Manager which read as follows: So, I was just laying here and in comes as--ole to feed me. All he did was slide the tray over to kind of like where my phone is, and he said want to eat? Yeah I said. I didn't even have time to sit up before he crammed the pizza in my mouth and then I kept trying to sit up and he kept pushing me down and he grabbed my tremoring hand and completely made fun of it and then I said, I want someone else. He said, You want some money?!! And when I kept trying to sit up and he kept pushing me back down and saying weird s--t like, why are you not eating? when my mouth was so full of pizza from the first bite and then he finally just gave up and left because he said he had more important things to do than sit there and play my games. Also, one of the times he physically forced me down with a piece of pizza in my mouth and I was like choking. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 5-day investigation report dated [DATE] regarding Resident #7's allegation of abuse against Nurse Aide (NA) #23 indicated the incident happened on [DATE] and the facility became aware of the incident on [DATE] at 4:15 PM. Resident #7 reported to the Unit Manager that NA #23 provided inappropriate feeding assistance. It was felt that he was feeding too fast and that he was not taken seriously. NA #23 was immediately removed from the facility. Additional Details included Resident #7 stated that he was fed inappropriately, held down (NA #23 was attempting to keep Resident #7 from coming out of the bed). Resident #7 became belligerent, hostile and NA #23 perceived him as beating the overbed table. NA #23 reported that since Resident #7's behavior was escalating, he made the decision to leave the room. Another nurse aide was assigned with the resident's meal. The incident was reported to law enforcement on [DATE] at 4:30 PM but the notification to the Department of Social Services was blank. Summary of Facility Investigation: After thorough investigation, it was determined that NA #23 concluded that Resident #7 would not require feeding assistance since the meal included finger foods. Resident #7 did self-consume snacks. Resident #7 became combative toward NA #23 and NA #23 left the room. A phone interview with the former Unit Manager (UM) on [DATE] at 1:02 PM revealed that she received a text message from Resident #7 that he had an issue with NA #23. Resident #7 relayed to her through text that NA #23 had come to feed him, made fun of him, fed him too fast, and he started choking. Resident #7 indicated on the text message that when he tried to sit up, NA #23 pushed him back down. The former UM stated that when she received the text message from Resident #7, she was in a meeting with the Interim Director of Nursing, the former Social Worker and the Administrator so she went ahead and told them about it. A phone interview with the Interim Director of Nursing (DON) on [DATE] at 12:24 PM revealed the former UM received a text message from Resident #7 which was alarming about an abuse allegation against NA #23. The Interim DON stated she completed an investigation by interviewing Resident #7 who indicated to her that NA #23 came into his room, and put his tray down on the bed. NA #23 came back and shoved pizza down into his mouth while he was in a lying position. Resident #7 further alleged that NA #23 took his hand and held him down. The Interim DON stated she did not understand why there was no copy of the text message in the investigation file because she remembered adding it, and she did not know what happened to it. The Interim DON also stated that she ended up unsubstantiating the allegation based on direction from the Administrator, and she was told that the incident was not witnessed. A phone interview with the former Social Worker (SW) on [DATE] at 12:39 PM revealed she was aware of Resident #7's text message to the former UM saying to come help him because NA #23 held him down on the bed with his hand and was trying to force pizza down his mouth. The former SW stated that she was asked to interview the alert and oriented residents regarding abuse after the incident, but she was not asked by the Administrator to notify the social worker at APS. An interview with the Administrator on [DATE] at 4:21 PM revealed she was notified of the situation with Resident #7 by the former UM. The former UM told the Administrator that Resident #7 texted her a concern about NA #23 regarding the manner and the way with how he went about feeding him. The Administrator stated she was informed of the text message, but she did not see the text message herself. The Administrator further stated that APS was contacted through the sheriff department. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview with the APS Social Worker on [DATE] at 12:20 PM revealed APS had not received any report within the last 9 months about Resident #7. She stated that she looked in their system and there was no documentation of APS being notified on anything about Resident #7. She added that she even went to the facility on [DATE] and nobody approached her to notify her about Resident #7's abuse allegation. A follow-up interview with the Administrator on [DATE] at 4:34 PM revealed she instructed the former SW to notify APS and she thought she did that. When the former UM told her about the text message from Resident #7, she couldn't remember verbatim what the former UM reported to her other than it was a situation in which Resident #7 texted to the former UM that NA #23 had brought the tray, attempted to feed him and it was too fast. The Administrator stated she did not have a reason as to why she did not look at the text message, and that she did not have any reason to disbelieve what the former UM told her. The Administrator stated that she did not see a copy of the text message in the investigation folder and if the Interim DON said she placed one on it, then she probably kept a separate folder. The Administrator continued to claim that she had never seen Resident #7's text message to the former UM.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and interviews with staff and the Medical Director, the facility failed to initiate emergency medical services for symptoms of a drug overdose. Resident #8 was slumped over, non-responsive with constricted pupils and impaired respirations. Resident #8 was observed by a facility staff member with no heart rate or respiratory rate and was pronounced dead on [DATE] at 3:50 PM. This deficient practice affected 1 of 3 residents reviewed for quality of care (Resident #8). Immediate jeopardy began on [DATE] when the facility failed to initiate emergency medical services. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: Resident #8 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, congestive heart failure (CHF), obstructive sleep apnea, anxiety disorder, and panic disorder. Effective [DATE] per physician's order, Resident #8's code status was Do Not Resuscitate (DNR). Resident #8's care plan initiated on [DATE] indicated the resident had COPD related to history of smoking, had chronic and acute respiratory failure, BiPAP (non-invasive ventilation) at night for obstructive sleep apnea, and oxygen via nasal cannula. Interventions included to monitor for difficulty breathing on exertion, signs and symptoms of acute respiratory insufficiency, and anxiety, and oxygen as ordered. Resident #8 also had a care plan initiated on [DATE] that he was on pain medication therapy related to chronic pain, COPD, and severe breathing problems. Interventions included to administer analgesic medications as ordered by physician, monitor/document side effects and effectiveness every shift, monitor for respiratory depression and for increased risk of falls. There was no mention of opioid or Narcan use in Resident #8's care plans. Resident #8 did not have an end of life care plan. A review of the physician's orders in Resident #8's medical record indicated an order for BiPAP with mode/settings: Inspiratory positive airway pressure (IPAP) 22, Expiratory positive airway pressure (EPAP) 18 - Apply at bedtime and remove in morning upon awakening for obstructive sleep apnea. This order started on [DATE] and was discontinued to [DATE] per recommendations from a pulmonologist as Resident #8 could not tolerate it and the resident wanted to be comfortable. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact, had no behaviors, had range of motion impairment to one side of the lower extremities, and used a wheelchair. He required supervision to partial/moderate assistance with all activities of daily living (ADL). The MDS further indicated that Resident #8 received both scheduled and prn (as needed) pain medications for complaints of frequent pain at a level of 8 (on a scale of ,d+[DATE] with 1 being minimal pain and 10 being severe pain). He had shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat, and used tobacco. He received anti-anxiety, antidepressant, antibiotic, diuretic, and opioid medications. He also received oxygen therapy but was not coded for receiving hospice care. A physician's order dated [DATE] in Resident #8's medical record indicated Naloxone (also known as Narcan) liquid 4 milligrams (mg)/0.1 milliliter (ml) 0.1 ml in nostril every 24 hours as needed for opioid depression/suspected opioid depression (overdose). CALL 911 TO ACTIVATE EMERGENCY RESPONSE. Naloxone liquid 4 mg/0.1 ml in alternate nostril from first dose if no response from first dose. Validate 911 emergency response activated. Nasal Narcan order - Call 911- May repeat dose every 10 minutes as needed for opioid depression/suspected opioid depression (overdose). A history and physical note documented by the Medical Director on [DATE] in Resident #8's medical record indicated Resident #8 was a long-term care resident who mobilized with wheelchair and was sitting in the hallway. Resident #8 endorsed no complaints of anxiety at this time. He recently was admitted to the hospital for treatment of COPD/CHF exacerbation, and stated he was feeling better after returning to the facility. Review of systems was negative except for cough and shortness of breath. Assessment and plan included COPD - improved since admission to hospital, and CHF - plan to give (diuretic) twice a day for 10 days. A review of Resident #8's Medication Administration Record for [DATE] indicated he received the following medications: * Buspirone (anxiolytic) 5 milligrams (mg) on [DATE] at 8:00 PM by Nurse #2 * Trazodone (antidepressant and sedative) 25 mg on [DATE] at 9:00 PM by Nurse #2 * Alprazolam (sedative use to treat anxiety and panic disorder) 1 mg on [DATE] at 9:00 PM by Nurse #2 * Hydroxyzine (antihistamine used to treat anxiety) 25 mg intramuscularly on [DATE] at 9:29 PM by Nurse #2 and [DATE] at 3:37 AM by Nurse #2 * Oxycodone-Acetaminophen (narcotic used to treat moderate to severe pain) ,d+[DATE] mg on [DATE] at 9:26 PM by Nurse #2 and [DATE] at 6:28 AM by Nurse #2 * Lorazepam (sedative) 1 mg on [DATE] at 9:25 PM by Nurse #2 and [DATE] at 6:29 AM by Nurse #2 * Naloxone liquid 4 mg in nostril on [DATE] at 9:34 AM and 9:54 AM by Nurse #14 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note dated [DATE] at 3:01 AM by Nurse #2 in Resident #8's medical record indicated: Resident #8 had been restless just about the entire shift. He wanted to argue about everything. He was so easily exerted with just movement. He was wearing oxygen via nasal cannula. He would not rest in the bed, and sat up on the side of the bed with feet hanging off. Both lower legs and feet were noted to be very edematous. Resident #8 was non-compliant with care. Staff not able to reason with this resident. He was using call bell constantly. See Medication Administration Record for all prn medications and scheduled medications given. A phone interview with Nurse #2 on [DATE] at 4:54 PM revealed she worked with Resident #8 on the night before he died . Nurse #2 stated that he rested occasionally but then he would wake up with breathing problems and would quickly be in a panic. Resident #8 had chronic breathing problems, and he wanted his medications given frequently. Nurse #2 shared that she gave all his medications that she could give that night, but nothing seemed to help his air hunger and he was very anxious. Resident #8 was independent with ADL and was able to go in and out of bed by himself. A phone interview with Nurse Aide (NA) #24 on [DATE] at 3:22 PM revealed she worked with Resident #8 on the night before he passed away. NA #24 stated that Resident #8 had increased shortness of breath that night, and he was very anxious. Resident #8 came to the nurses' station that night and then eventually went back to bed in the early morning. A progress note dated [DATE] at 9:36 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 was given Narcan per order. Oxygen saturation 68% (normal value 95% or higher), resident not responding to painful stimuli, pupils constricted. (Small pupils or constricted pupils are common symptoms of opioid overdose.) Narcan given in nostril. Resident now 95% on oxygen. Blood pressure ,d+[DATE] (normal value less than ,d+[DATE]), heart rate 84 (normal value 60 to 100 beats per minute), respirations 18 (normal value 12 to 18 breaths per minute) and regular. Another progress note dated [DATE] at 9:47 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 now resting with eyes closed. Oxygen saturation 98%. No signs/symptoms of pain or shortness of breath. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with Nurse #14 on [DATE] at 10:56 AM revealed she was working as the weekend supervisor on [DATE] when Agency Nurse #20 alerted her. Nurse #20 told her that she had no idea what to do about Resident #8. When Nurse #14 came into Resident #8's room, he was very sweaty and was not responding. Resident #8 was sitting in his wheelchair at his bedside, and he was slumped over. Nurse #14 stated that she was afraid Resident #8 might fall forward off his wheelchair, so NA #20 helped her put him back in bed. Nurse #14 stated that she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications. Nurse #14 further stated she gave him the two doses of Narcan which perked him up. Nurse #14 said she thought Nurse #20 spoke with the on-call provider while she was busy taking care of Resident #8. Nurse #14 also stated that she did not think to call 911 because it seemed like the two doses of Narcan worked, and she noted on the physician's order that she could give another dose after 10 minutes if the first one did not work. After Nurse #14 administered the second dose, she observed that Resident #8's oxygen saturation was within normal limits, and he was talking to her although he said that he was tired and just wanted to lay there in the bed. Nurse #14 stated that Nurse #20 told her that she had called the doctor, and she thought that Nurse #20 had also called 911. Nurse #14 commented that she thought Nurse #20 was going to call 911 because Resident #8 was Nurse #20's resident, and after giving Resident #8 the two doses of Narcan, Nurse #14 went back to the other side of the building. Nurse #14 stated that she knew this was Nurse #20's first day working at the facility. She denied having been told by the Social Worker to call EMS after she gave him Narcan. Nurse #14 stated she did not think she needed to call 911 because Resident #8 responded to the Narcan doses, and he was DNR. Nurse #14 further stated that she was not familiar with the facility's policy for Narcan administration and had not received training on how to administer Narcan. She found out later around 2:00 PM that Resident #8 took a turn for the worse but because the ADON told her that morning after she gave him Narcan that Resident #8 was DNR, and that he was dying, she didn't think there was anything else she should have done. A progress note dated [DATE] at 10:00 AM by Agency Nurse #20 in Resident #8's medical record indicated: Resident #8 was sitting up in wheelchair, very difficult to arouse. Oxygen saturation was 71% on oxygen via nasal cannula. Resident #8 was placed back to bed with head of bed elevated. Somewhat more responsive but continued to nod off. Oxygen saturation increased to the low 80% with deep breaths. Narcan administered by Nurse #14. Narcan somewhat effective, more alert and verbal. Morning medications held. A second progress note dated [DATE] at 12:58 PM by Nurse #20 in Resident #8's medical record indicated: Resident #8 difficult to arouse at this time. Responded to sternal rub (application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) with mumbles. Oxygen on per order via nasal cannula. BiPAP (bilevel positive airway pressure which is a form of non-invasive ventilation therapy used to help you breathe) placed on. More verbal and alert at this time. A third progress note dated [DATE] at 3:50 PM by Nurse #20 in Resident #8's medical record indicated: Upon observation, no heart rate or respiratory rate noted. Responsible party aware. Nurse Practitioner aware, order to release body to the funeral home received and noted. Funeral home contacted per family request. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with Nurse #20 on [DATE] at 12:52 PM revealed she took care of Resident #8 on the day he died . Nurse #20 stated Resident #8 was not alert and was unresponsive, so she got Nurse #14 to come in his room to see him and they took his vital signs which were the same vital signs recorded by Nurse #14 in her 9:36 AM progress note. Nurse #20 stated that Resident #8's oxygen saturation level was very low. She could not recall the exact numbers, but she remembered it being in the 70s. Nurse #20 said that Nurse #14 administered Narcan to Resident #20. Nurse #20 further stated she was not sure why EMS (Emergency Medical Services) was not notified, and she did not know at the time that EMS was supposed to be notified when Narcan was administered. Nurse #20 shared that she did not look at the order for Narcan because she was not the one who administered it to Resident #8. Nurse #20 recalled Resident #8's pupils being very pinpoint, and he was very lethargic on the day that he died but because Nurse #14 told her that Resident #8 was DNR and that there was nothing else they could do for him, she did not think about calling EMS. Nurse #20 stated she was not familiar with Narcan and had never given it before. She also did not receive training on Narcan administration at the facility prior to her working there. A follow-up phone interview with Nurse #20 on [DATE] at 12:26 PM revealed NA #21 alerted her that Resident #8 was lethargic. When Nurse #20 checked Resident #8's oxygen saturation, it was dropping so she asked Nurse #14 for help. Resident #8 woke up somewhat after he received the two doses of Narcan. During the interview, Nurse #20 stated that she was very nervous because she thought that she might be in trouble. Nurse #20 explained that [DATE] was her very first day working at the facility as an agency nurse and she did not have access at the time to the clinical messaging platform that the facility used to contact the on-call providers. Nurse #20 stated that she did not think about calling the on-call provider because she thought that Nurse #14 took over Resident #8's care when she gave him the Narcan. Nurse #20 explained that during this incident, she was still trying to get her medication pass done, and she thought Nurse #14 was going to take care of Resident #8. Nurse #20 further shared that she asked Nurse #14 if they needed to send Resident #8 to the hospital, but Nurse #14 told her no, and that they were not going to do anything for Resident #8 because he was DNR. Nurse #20 clarified that the progress note she documented in Resident #8's chart at 10:00 AM was entered late and that she referred to this note about what happened to Resident #8 before receiving the two Narcan doses. Nurse #20 confirmed that Resident #8 was somewhat more responsive after the two doses of Narcan, but she was not familiar with him because this was her first time taking care of Resident #8, so she did not know what was normal for him. Resident #8 stayed in bed asleep, and his oxygen saturation went up a little, but he got worse in the afternoon when he became lethargic and unresponsive with no heart rate and no breathing. She notified Nurse #14 but again Nurse #14 told her there was nothing they could do for Resident #8. Nurse #20 stated she could not remember why she did not send Resident #8 to the hospital after he received the two doses of Narcan. She did not think of administering the Narcan again and did not think about calling 911. She further shared that she had never administered Narcan before which was why she asked for help from Nurse #14. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Health & Rehab of Sylva	417 Cloverdale Road Sylva, NC 28779

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with Nurse Aide (NA) #21 on [DATE] at 11:03 AM revealed on the day that Resident #8 passed away, he was very lethargic, and she told Nurse #20 that he was unresponsive. NA #21 stated that this was not normal for Resident #8 because he was usually up and about and could get around by himself. NA #21 stated that they tried to wake him up multiple times, but he had extremely low oxygen saturation level according to what Nurse #14 and Nurse #20 told her. He was wheezing and although she could not recall the exact oxygen saturation, she stated that it was in the 70s based on what she remembered Nurse #20 telling her. NA #21 further stated that they tried to sit him up but over the next few hours, he did not get any better. NA #21 shared that Resident #8 briefly opened his eyes after receiving the Narcan doses but within 20 to 30 minutes he was back to being lethargic. Resident #8 was able to answer questions, but he acted tired and went back to sleep. He continued to have wheezing and a few hours later he was actively dying based on what Nurse #14 told her. She reported this to Nurse #20, and she placed Resident #8 on BiPAP which was at the bedside. NA #21 stated she went on to take care of the other residents on the hall so NA #20 could sit with Resident #8. Then they provided postmortem care to Resident #8. A phone interview with NA #20 on [DATE] at 9:22 AM revealed he took care of Resident #8 when he died . NA #20 stated that it was the most horrific experience he had ever had. Resident #8 sat in his wheelchair and had his head down on the rolling table. Resident #8 was slumped over, and he was jerking in and out of consciousness, so they put him back into bed. NA #20 stated that Resident #8 was not able to speak that day. He was very short of breath. NA #20 reported that Resident #8 usually complained of shortness of breath, but he was always alert and oriented, and he was able to move around in his room by himself. NA #20 said that he told Nurse #14 that Resident #8 was not responding and was lethargic. After Nurse #14 gave Resident #8 the Narcan, he woke up for a few minutes and then after a brief period he was back to being unresponsive. NA #20 added that he continued to tell Nurse #20 and Nurse #14 that something was not right with him because his eyes were pinpoint and glazed over even when his head was laid on the pillow. His head was floppy, and his limbs were flaccid. NA #20 further shared that Resident #8 had severe edema in his lower extremities which was worse than usual. He said he attempted to check a pedal pulse on Resident #8 because his legs were so swollen, but he was unable to obtain a pedal pulse for the remainder of the day. He stated that he did not check a pulse anywhere else on Resident #8's body. NA #20 stated that Nurse #14 told him that Resident #8 was actively dying and that there was nothing to be done because he was DNR. NA #20 stated that he stayed with Resident #8 holding his hand because he had known previously that he was afraid of dying alone, and then Resident #8 got quiet and then NA #20 realized that he had passed away. NA #20 hollered for Nurse #20 at approximately 3:50 PM and they came to check on Resident #8 who was pronounced dead. NA #20 provided postmortem care with NA #21 before the funeral director got Resident #8's body. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with the former Social Worker (SW) on [DATE] at 12:45 PM revealed she was the manager on duty which meant she was in charge of the facility in the absence of the Administrator on [DATE]. The former SW stated that when she came in that morning around 9:30 AM, Nurse #14 told her that Resident #8's pupils were pinpoint, and that they needed help to put him back into bed. The former SW stated she observed Resident #8 slumped over in his wheelchair and she thought he was going to die right there. Resident #8's pupils were pinpoint, and she watched Nurse #14 give Resident #8 two doses of Narcan. The former SW further stated that she told Nurse #14 that the facility's policy was to immediately call EMS, call the doctor and send the resident to the hospital after the resident was given Narcan. The former SW explained that she was training an activity staff member that day, so she left the room after Resident #8 received the two doses of Narcan and she said she thought Nurse #14 was going to send Resident #8 out to the hospital afterwards, but she did not. Later that day, around 2:00 PM, Nurse #14 reported to her that Resident #8 took a turn for the worse, so the former SW asked Nurse #14 if she was going to send Resident #8 out. Nurse #14 did not answer her and just looked at her. The former SW stated that she thought Nurse #14 should know what she was supposed to do because she was the nurse. The former SW stated that she did not want to interfere with nursing because she worked in another department, and she could not tell them what they were supposed to do. The former SW stated that she tried to call the Administrator to alert her as to what was happening in the facility, but she could not get her on the phone. An initial joint interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on [DATE] at 1:11 PM. The DON stated that she was not at the facility when Resident #8 died so she did not remember anything that went on that day. The DON stated that she would have to look back at the notes, but she knew that the former Social Worker and Nurse #14 were at the facility on [DATE]. The ADON stated that she knew Resident #8 passed away, but it was expected that he was going to die because he had end-stage COPD and respiratory failure. The ADON stated that from what she remembered, Resident #8 was found unresponsive, but she denied knowing any details regarding Resident #8 receiving Narcan. The ADON shared that each resident had a standby order for Narcan especially if they had opioid medications in cases of opioid overdose, but she was not sure whether the order indicated that they were supposed to call 911 when administering Narcan. The DON stated that if it was specified on the Narcan order to call EMS, the nurses should have followed what was specified on the order. A follow-up interview with Nurse #14 on [DATE] at 8:32 AM revealed she talked to the ADON after she gave two doses of Narcan to Resident #8 and the ADON told her that it was fine, and that she didn't have to do anything else because Resident #8's code status was DNR. Nurse #14 further stated that if the ADON had told her to call 911, she would have called 911, but because he was DNR, the ADON told her they did not need to do anything. Nurse #14 also shared that around 2:00 PM on [DATE] when Resident #8's condition was getting worse, she asked the former Social Worker if she needed to send him out to the hospital. Nurse #14 claimed that the former Social Worker told her that she didn't have to send him out to the hospital because he was DNR. Nurse #14 further shared that Resident #8 had improved after the first dose of Narcan, but she did not know the reason for the persistent lethargy even while he was in bed, so she gave her another dose of Narcan. A follow-up phone interview with the former SW on [DATE] at 11:18 AM revealed she did not say to Nurse #14 not to send Resident #8 to the hospital because he was DNR. The former SW stated that it was not her call. She added that Nurse #14 was the nurse on the floor, and she should have taken care of Resident #8. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow-up interview with the ADON in the presence of the DON on [DATE] at 3:29 PM revealed that the ADON could vaguely remember if she called or texted Nurse #14 on [DATE] after Nurse #14 gave the two Narcan doses to Resident #8. The ADON stated that she couldn't remember when her conversation with Nurse #14 was and what time, but that the ADON was not surprised that Resident #8 had died but she was surprised that Nurse #14 had given him Narcan. The ADON stated she questioned Nurse #14 why she gave Resident #8 Narcan when he was expected to die. The ADON explained that she was doing verbal education to the staff to help them understand how sick he was. Whenever Resident #8 had issues with his breathing, he wanted to go to the hospital where they would just give him a rescue BiPAP and intravenous diuretics, and then send him back to the facility. The ADON stated she did not remember her exact response to Nurse #14 about the two Narcan doses, but she recalled Nurse #14 telling her that Resident #8 responded a little bit to the Narcan dose. The ADON further explained that she remembered telling Nurse #14 that Resident #8 was unresponsive because he was actively dying. The ADON recalled Nurse #14 told her Resident #8 responded a little bit after she gave him Narcan. An interview with the Medical Director (MD) on [DATE] at 10:21 AM revealed he last saw Resident #8 on [DATE] when he visited him after he had just gotten back from the hospital for COPD and CHF, and he seemed to be doing fine during the visit. The MD stated that Resident #8 was a long-term care resident and his plan of care included providing assistive care and managing his chronic medical issues. The MD stated that he was not notified when Resident #8 died but he found out about it the next day he visited the facility. The MD stated that he did not know that they administered Narcan to Resident #8, and he was not familiar with the facility policy for Narcan. The MD stated that if the policy indicated for staff to notify EMS when administering Narcan, then they should have followed that. The MD confirmed that low oxygen saturation and pupil constriction were signs of overdose, and that Resident #8 should have been sent out to the hospital on [DATE]. The MD added that if an on-call provider was notified about the Narcan doses, then there would be a note in Resident #8's chart and they would have ordered to send him out to the hospital. Resident #8's death certificate indicated date of death was [DATE] and the immediate cause of death was myocardial infarction (heart attack) with the following diagnoses listed as underlying causes: coronary artery disease and congestive heart failure. A follow-up phone interview with the MD on [DATE] at 11:39 AM revealed he put myocardial infarction (MI) on Resident #8's death certificate because that was the most likely cause of his death but if he had known that the nurses had to give him Narcan, he probably would not have put MI without doing further investigation into the cause of his death. The MD stated that he could not put possible overdose on Resident #8's death certificate, and that he would need to have a toxicology report done but this was rarely done unless the family member requested for one to be done. The MD stated that a toxicology report could verify the cause of death but since they did not do this anymore, he said he didn't know what he would have put as the cause of death without investigating further. The MD explained that Narcan was just a temporary fix, and it did not fix or correct the cause of the lethargy. Narcan also had a tendency to wear off quickly which was why it could be given every 10 minutes or so, but it would be nice to have EMS around in case the resident went back into depression. The MD added that Narcan was only used in cases of emergency and any resident who received it needed to be observed and monitored closely. The MD further explained that a positive response from Narcan meant that the Narcan was working in terms of reversing whatever caused the unresponsiveness, but it was only effective up to a certain extent. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with the Administrator on [DATE] at 11:55 AM revealed she was not aware of Resident #8's passing until the Monday when she came in. The Administrator stated Resident #8 had been having repeated respiratory issues, and she knew that he had been advancing with his COPD and that he was end-stage which meant there was not a lot they could do for him. She stated that she knew Resident #8 had just been through two previous hospitalization s for respiratory distress where he received treatment. The Administrator stated that she did not know the specific date that she found out about Resident #8 having been given Narcan without guessing. She could not say whether Resident #8 should have received emergency treatment after receiving the two Narcan doses. The Administrator was notified of immediate jeopardy on [DATE] at 12:00 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 activate emergency response for Resident #8 after Nurse #14 administered two doses of Narcan on [DATE] at 9:34 AM and 9:54 AM with positive response for suspicion of drug overdose. The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by [DATE]. Licensed nursing staff that are not available on or before [DATE] will not be scheduled until the education has been completed. The actions the facility will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS to the licensed nurse addressing any challenges or barriers in the use of Narcan and/or the activation of the emergency response. Re-education was provided to licensed nursing staff about the activation of the emergency response when Narcan is administered. * Agency licensed nurses working at the facility will receive education on activating emergency response when administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee). Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The specific actions the facility will take to alter the system failure to prevent a serious outcome from reoccurring are: * The facility has re-educated the licensed nursing staff on the use of Narcan and activation of the emergency response per physician orders by [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The actions the facility will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers. * Agency licensed nurses working at the facility will receive education on notification to the medical provider on administration of Narcan for a suspected overdose by the DNS/ Assistant Director of Nursing (designee). * The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system, which is denoted in the revised Narcan Administration Policy [DATE]. The alleged date of immediate jeopardy removal is [DATE]. The credible allegation for the immediate jeopardy removal was validated on [DATE] with a removal date of [DATE]. A review of in-service education records dated [DATE] revealed education was provided to nurses including agency nurses on the activation of emergency response upon administration of Narcan, and ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with the nursing staff including agency nurses revealed they had been educated on activating EMS and notifying the medical provider of any resident who receives Narcan for suspected overdose, and the revised Narcan administration policy. A review of the revised Narcan administration policy dated [DATE] indicated the nurse who responds to the suspected overdose will direct another staff member to activate EMS. The facility's date of immediate jeopardy removal of [DATE] was validated.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 41069 Based on observation, record reviews and visitor, family, staff, and Medical Director interviews, the facility failed to enforce their smoking policy, monitor a resident who had a history of non-compliance with the smoking policy for storage of smoking materials, and implement interventions to prevent a resident from vaping in his room with his oxygen on and while his roommate (Resident #6) was in the room. Resident #8, who was on oxygen, was found to have a vape pen in his possession on 2/2/24, 2/16/24, and 3/1/24, and was observed vaping while on oxygen on 3/1/24. An electronic cigarette or vape pen (vaporizer) is a device that simulates tobacco smoking. It contains a heating element which reaches high temperatures and can ignite nasal cannula with oxygen flowing. Vaping while on oxygen placed Resident #8 and Resident #6 at increased risk for fire and combustion. This posed a high likelihood of serious injury to all residents. The facility also failed to prevent a resident with moderate cognitive impairment, a history of wandering and exit seeking behaviors, delusional behavior, and delusions from exiting the facility unsupervised and without staff knowledge (Resident #1). Staff interviews revealed an emergency exit door alarm in hallway of the 200 unit sounded around shift change (7:00 AM) on 2/20/24 and staff disarmed the alarm without initiating a Code [NAME] (the facility elopement protocol), without conducting a full resident head count to ensure all residents were in the facility at the time, and without conducting a thorough search of the area which was accessible from the exit. Between 7:05 AM and 7:10 AM, a visitor arrived at the facility and found Resident #1 outside, unsupervised, wearing a thin night gown and socks on her feet, without shoes, and holding multiple pieces of mail. The resident was discovered at the front of the facility approximately 120 yards from the 200 hall exit door. The visitor indicated Resident #1 appeared cold, so he had the resident sit in his car with the heat on until the transportation aide arrived at the facility to open the facility door around 7:30 AM. There was a high likelihood of serious injury from falls and hypothermia as temperatures were recorded at 23 degrees Fahrenheit at the approximate time Resident #1 was found outside. In addition, the facility failed to protect a resident from exposure to an illegal substance. As a result, Resident #6 was found to have experienced altered mental status, impaired physical mobility, and slurred speech. The drug screening test conducted by Nurse #2 confirmed Resident #6 was positive for tetrahydrocannabinol (THC- a compound found in cannabis/marijuana plants). These deficient practices affected 3 of 5 residents reviewed for risk for accidents. Immediate jeopardy began on 2/20/24 for Resident #1 when Resident #1 exited the facility and wandered approximately 120 yards from the exit door in temperatures below freezing (approximately 23 degrees Fahrenheit) outside. Immediate jeopardy began on 3/1/24 for Resident #8 when Resident #8 was observed vaping while on oxygen in the room and the facility failed to have a monitoring system in place for unsecured smoking material. Immediate jeopardy was removed on 5/18/24 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of G (actual harm that is not immediate jeopardy) for example # 3. The findings included: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The facility's smoking policy with the revision date of 2/2023 indicated it is the policy of the facility to allow residents to smoke tobacco-based products in the designated smoking area under staff supervision only. Smoking is allowed only during designated hours and monitored by staff during these times. The designated smoking area is the outside patio. For safety reasons, residents may not possess smoking paraphernalia (including, but not limited to tobacco products which include cigarettes, cigars, pipes along with, electronic cigarettes, lighters, matches, or other smoking material). The aforementioned items must be turned over to facility staff so they may safely store them. Any resident observed not following smoking policies may have their smoking privileges revoked. Resident #8 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. A review of Resident #8's Smoking Evaluations in his medical record dated 1/11/23, 1/18/23, 5/5/23, and 2/8/24 indicated Resident #8 was a supervised smoker. The smoking assessments were completed by nurses. A physician's order dated 1/26/24 in Resident #8's medical record indicated oxygen via nasal cannula at 2 liters per minute continuously. Resident #8's Treatment Administration Record for February and March 2024 indicated he received oxygen via nasal cannula at 2 liters per minute continuously for COPD. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact, had no behaviors, had range of motion impairment to one side of the lower extremities, and used a wheelchair. He required supervision to partial/moderate assistance with all activities of daily living. The MDS further indicated that Resident #8 had shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat. Resident #8 used tobacco and received oxygen therapy. A review of Resident #8's medical record indicated no smoking contracts signed prior to 2/5/24. A smoking contract was signed on 2/5/24 by Resident #8 and the former Social Worker and on 2/17/24 by Resident #8, the former Social Worker and Nurse #3. Resident #8's care plan last reviewed on 2/20/24 indicated the resident had COPD related to history of smoking, had chronic and acute respiratory failure, (non-invasive ventilation) at night for obstructive sleep apnea, and oxygen via nasal cannula. Interventions included to monitor for difficulty breathing on exertion, signs and symptoms of acute respiratory insufficiency, and anxiety. Resident #8's care plan last reviewed on 2/20/24 indicated Resident #8 smoked and needed to be supervised when he smoked. Interventions included that all smoking materials be kept at the nurses' station and that he would ask to get them before he went outside to smoke. Resident #8 had been informed of the facility smoking policy and staff to remind him as indicated. He needed staff to accompany him to the designated smoking area and staff needed to stay with Resident #8 until he was done smoking and then accompany him back to his unit. The care plan indicated oxygen should be removed before smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Social Services note in Resident #8's medical record dated 2/4/24 indicated on Friday, (2/2/24), at 12:00 PM, the Social Worker (SW) was notified Nurse #3 that Resident #8 had a vape in his room. The Social Worker and Nurse #3 went in and removed it. A phone interview with the former Social Worker (SW) on 5/9/24 at 10:15 AM revealed Resident #8 was non-compliant with the facility's smoking policy. Resident #8 was observed with a vape pen in his room on 2/2/24, but she couldn't remember if he was observed using it. Nurse #3 removed the vape pen from Resident #8's room. The former SW reported Resident #8 had been educated on the facility's smoking policy and she was responsible for completing the smoking contracts. The former SW stated she did not know why there wasn't a smoking contract in his medical record prior to 2/5/24. She also stated that she did not know where the resident was getting his vape pens from. A phone interview with Nurse #3 on 5/6/24 at 2:37 PM revealed on 2/2/24, she observed a vape pen on Resident #8's bedside table. She notified the former SW and they both removed it from the room. Nurse #3 stated she did not observe Resident #8 vaping in his room with his oxygen on, but he was educated that he could not keep his vape pen in the room. Nurse #3 stated Resident #8 would not tell them how he obtained the vape pen. Nurse #3 further stated that Resident #8 had vape pens removed from his room many times after 2/2/24, and he also had cigarettes that he kept in his room which he smoked outside in the patio. Nurse #3 stated she did not know how Resident #8 was obtaining the vape pens and the cigarettes. Nurse #3 stated that she notified the former SW after all the times she removed vape pens from Resident #8's room. She shared that a staff member was supposed to be outside when the residents were smoking but unfortunately, they had to pass out three cigarettes for each smoker and a lot of times, there was approximately 20 residents out there at a time. So therefore, they were not able to keep an eye on the residents to ensure they were not smoking things or takings things they were not supposed to be sharing. A review of a Smoking Policy/Contract signed by Resident #8 and the former Social Worker on 2/5/24 indicated the following information under Violation: Resident Policy Enforcement - 1. First Resident Infraction: Immediate notification of the Administrator and the Director of Nursing (DON) of any suspected/known smoking policy infraction, completion of an incident form with witness statements and full investigation of the infraction, prompt meeting with the resident by members of the Interdisciplinary Team (IDT) to review the smoking policy violation and the smoking policy once again, re-performance of the smoking assessment and individualized safe smoking plan for comprehensiveness, and a written witnessed warning regarding the infraction. 2. Second Resident Infraction: Immediate notification of the Administrator and the DON of any suspected/known smoking policy infraction, completion of an incident form with witness statements and full investigation of the infraction, prompt meeting with the resident by member of the IDT to review the smoking policy violation and the smoking policy once again, re-performance of the smoking assessment and individualized safe smoking plan for comprehensiveness, and revocation of smoking privileges for up to two weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A phone interview with NA #20 on 5/7/24 at 9:22 AM revealed Resident #8 wore oxygen and was a supervised smoker in the outside patio, but NA #20 often found vape pens in his room. NA #20 stated that whenever he found Resident #8 smoking a vape pen in his room with his oxygen on, he would tell Nurse #2 or the Social Worker who would confiscate the vape pens. NA #20 said he could not remember the specific dates he had observed Resident #8 smoking a vape pen with his oxygen on, but he knew that he was not supposed to be doing that. NA #20 stated that he knew that according to the smoking contract, Resident #8 was supposed to lose his smoking privileges, but he never did. An interview with Nurse #14 on 5/10/24 at 8:32 AM who was the weekend supervisor revealed she always observed Resident #8 vaping in his room with his oxygen on. Nurse #14 stated that she would often smell the vape, and she would confiscate it from Resident #8. Nurse #14 stated that she had no idea where Resident #8 was getting his vape pens from, but she always reported this to the former SW to whom she turned in the confiscated vape pens. Nurse #14 confirmed that she removed the vape pen from Resident #8's room on the morning of 3/2/24, along with the former SW. Resident #6, roommate of Resident #8, was admitted to the facility on [DATE]. The quarterly MDS assessment dated [DATE] indicated that Resident #6's cognition was intact. An interview with Resident #6 on 5/22/24 at 2:45 PM revealed he never saw Resident #8 use a vape pen while he was using his oxygen. Resident #6 stated that Resident #8 never gave him a vape pen, and he never asked him for one. A phone interview with the former Social Worker (SW) on 5/9/24 at 10:15 AM revealed when vape pens were found in Resident #8's room, she would re-educate him and let him sign a new smoking agreement. The former SW stated that the Administrator would not let them revoke Resident #8's smoking privileges or issue a discharge notice even when he had repeated violations of the smoking contract. The former SW stated that she placed the confiscated vape pens in the bottom drawer in a filing cabinet in her office which she always kept locked. During a joint interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/10/24 at 2:34 PM, the DON stated that the Social Worker handled the smoking contracts while nursing handled the smoking assessments. When a resident violated their smoking contract, this was dealt with by the Social Worker and the Administrator. The DON stated that she did not know enough about vape pens, and that she did not know whether it was unsafe if a resident vaped while he was on oxygen. The ADON stated this would have been dealt with immediately, but she had not seen this happen. The DON stated that the nurse could take the vape pen away if they felt that it was a safety hazard, and that they would have to contact the Social Worker. The ADON stated that she was aware that staff saw vape pens in Resident #8's room, but she was not sure whether they belonged to him or his roommate. The DON stated that the residents were allowed to vape in the designated smoking area but not inside their rooms. The DON stated the vape pens and cigarettes were supposed to be locked up, and the residents were not supposed to have them in their person. The ADON added that they had a lot of smokers at the facility, and it was hard to control them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the Administrator on 5/10/24 at 4:34 PM revealed she was aware of staff finding vape pens in Resident #8's room but she couldn't tell when they first found them. The Administrator stated it happened on more than one occasion. Staff told the former SW that Resident #8 had a vape pen in his room, and she went in to talk to him, but she didn't know what she had explained to Resident #8. The Administrator shared that she talked to Resident #8 shortly after he signed his third smoking contract, and she told him that he could vape, but the vaping materials would need to be locked up. The Administrator said that they had multiple discussions and reviews of the smoking policy with Resident #8, but she could not enforce the smoking policy and issue him a discharge notice because they could not find an appropriate place for him. The Administrator stated that when it came down to it, they needed to go through the proper discharge. She added that most of their residents would breach the smoking policy, and all they could do was to continually monitor and observe, and ask for their cooperation. A follow-up interview with the Administrator on 5/22/24 at 4:35 PM revealed she was aware of an event where the nurse aides observed or suspected Resident #8 of vaping while he was on oxygen, and the nurse aides notified the former SW. The former SW interviewed Resident #8 about vaping with his oxygen on, but he would not give up his vape pens. Resident #8 said he should be able to vape when he wanted to, and he did not think vaping was in the same category as smoking. The former SW told the Administrator about this the following week right around the same time he was sent out to the hospital. The Administrator further stated that when Resident #8 came back from the hospital in February 2024, he asked her if he could vape, and she told him that he could, but he would have to go outside and follow the smoking policy, and he could not keep the smoking/vaping materials in his room. The Administrator said she did not know that Resident #8 had vape pens until the nurse aides and the former SW observed him with them, and he did not want to give them up until the former SW talked to him. The Administrator also stated that there was not a point where she thought about revoking Resident #8's smoking privileges because he had been compliant and honest with her. The Administrator was notified of immediate jeopardy on 5/15/24 at 10:54 AM. The facility submitted 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 enforce their smoking policy and implement interventions to prevent a resident (Resident #8) from vaping in his room with his oxygen on and while with a roommate in the room. Electronic cigarettes or vape pens contain a heating element which reaches high temperatures and can ignite nasal cannula with oxygen flowing. Vaping while on oxygen placed Resident #8 and his roommate at increased risk for fire and combustion. This had a high likelihood of serious injury to all residents. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The facility needs to have effective systems in place to supervise residents while smoking, enforce their smoking policy, and prevent residents from keeping smoking paraphernalia in the rooms. The facility needs to have monitoring systems in place for unsecured smoking material. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the smoking policy revised on 5/16/24 indicated if the resident is on oxygen therapy and refuses to allow the facility to conduct a room search, the police will be notified of the unsafe situation. An observation of smoking on 5/22/24 at 1:37 PM revealed there were 18 residents in the smoking porch. There was a container by the door to the smoking area for oxygen storage, but no oxygen tanks were present. Two staff members were observed assisting the smokers with applying smoking aprons, and providing cigarettes and lighting them for the residents. No resident was observed smoking while on oxygen, and none were observed vaping. All lit cigarettes were disposed of in the appropriate containers in the outside patio at the end of the session. Interviews with residents who smoked and/or vaped revealed they were educated on the smoking policy and about not keeping smoking items such as cigarettes, vapes, and lighters in their person and in their rooms. They also stated understanding regarding the importance of not smoking or vaping while on oxygen or while in close proximity to another resident on oxygen. A review of the audits completed on 5/15/24 indicated the smoking list was updated to include residents who also used vape pens. Smoking assessments were completed on 5/16/24. A review of medical records of residents who smoked and/or vaped revealed the residents and family members were advised not to bring smoking materials including vape pens to the residents in the building, and instead, to turn them in to the nurse or start an account with the business office who would purchase smoking materials for them. They were also reminded that the residents were not allowed to have any smoking material including vape pens on them or in the rooms, and that all smoking materials must be given to the nurse or activities so that they could be safely stored. The facility's date of immediate jeopardy removal of 5/18/24 was validated. 42090 2. Resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, bipolar disorder, anxiety disorder, insomnia, history of falling, difficulty walking, unsteadiness on feet, muscle weakness, panic disorder, schizoaffective disorder, and cognitive communication deficit. A review of the facility floor plan revealed Resident #1 resided on the 200 hall unit near the 100/200 hall nurses station and approximately 7 resident rooms from the 200 hall emergency exit door. An elopement risk assessment was completed on the following dates prior to her recent readmission: 8/1/23 and 11/26/23. Resident #1 was determined to be at risk for elopement on both assessments. A review of Resident #1's Admission/Readmission nursing assessment dated [DATE] revealed she had risk alerts for falls and may attempt to exit with wandering listed under mood and behaviors. A review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had moderate cognitive impairment. Resident #2 was not coded with wandering behaviors during the 7-day lookback and required supervision for ambulating 50 feet and make 2 turns. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and staff interviews, the facility failed to ensure nursing staff were trained and competent with responding to medical emergencies, activating emergency procedures with emergency medical services, and notifying medical providers for 1 of 4 residents (Resident #8) reviewed for neglect. Nursing staff failed to notify a medical provider of significant changes in a resident's condition who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction, and failed to immediately initiate emergency procedures with 911. Resident #8 expired on [DATE]. This was for 2 of 2 staff members reviewed for competency (Nurse #20 and Nurse #14). Immediate jeopardy began on [DATE] when nursing staff did not demonstrate competency in responding to a medical emergency. The immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective for ensuring all staff are trained and competent before caring for residents in the facility. The findings included: A review of the employee file for Nurse #20 indicated verification of an active license to practice in the state, and a checklist entitled, Agency Staff Facility Orientation. The checklist was initialed and signed by Nurse #20 on [DATE]. Included in the checklist were emergency codes, Narcan, and code blue. A review of the employee file for Nurse #14 indicated she was hired on [DATE] as a charge nurse. A new-hire orientation checklist was completed on [DATE] and verification of an active license to practice in the state was done. The checklist dated [DATE] indicated Nurse #14 was checked off on the location of fire alarms, location and operation of emergency exits, location of fire extinguishers, fire plan, evacuation procedure, emergency telephone numbers, door alarms, and emergency generators. The Nurse Supervisor job description was signed by Nurse #14 and the Director of Nursing on [DATE]. Included in the job description were to assist the charge nurse in monitoring seriously ill patients, and to notify the attending physician and next-of-kin when there is a change in the resident's condition. A progress note dated [DATE] at 9:36 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 was given Narcan per order. Oxygen saturation 68% (normal value 95% or higher), resident not responding to painful stimuli, pupils constricted. (Small pupils or constricted pupils are common symptoms of opioid overdose.) Narcan given in nostril. Resident now 95% on oxygen. Blood pressure ,d+[DATE] (normal value less than ,d+[DATE]), heart rate 84 (normal value 60 to 100 beats per minute), respirations 18 (normal value 12 to 18 breaths per minute) and regular. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Health & Rehab of Sylva	417 Cloverdale Road Sylva, NC 28779

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Another progress note dated [DATE] at 9:47 AM by Nurse #14 in Resident #8's medical record indicated: Resident #8 now resting with eyes closed. Oxygen saturation 98%. No signs/symptoms of pain or shortness of breath. A progress note dated [DATE] at 10:00 AM by Agency Nurse #20 in Resident #8's medical record indicated: Resident #8 was sitting up in wheelchair, very difficult to arouse. Oxygen saturation was 71% on oxygen via nasal cannula. Resident #8 was placed back to bed with head of bed elevated. Somewhat more responsive but continued to nod off. Oxygen saturation increased to the low 80% with deep breaths. Narcan administered by Nurse #14. Narcan somewhat effective, more alert and verbal. Morning medications held. A second progress note dated [DATE] at 12:58 PM by Nurse #20 in Resident #8's medical record indicated: Resident #8 difficult to arouse at this time. Responds to sternal rub (application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli) with mumbles. Oxygen on per order via nasal cannula. BiPAP (bilevel positive airway pressure which is a form of non-invasive ventilation therapy used to help you breathe) placed on. More verbal and alert at this time. A phone interview with Nurse #20 on [DATE] at 12:52 PM revealed she took care of Resident #8 on the day he died . Nurse #20 stated Resident #8 was not alert and was unresponsive, so she got Nurse #14 to come in his room to see him and they took his vital signs which were the same vital signs recorded by Nurse #14 in her 9:36 AM progress note. Nurse #20 stated that Resident #8's oxygen saturation level was very low. She could not recall the exact numbers, but she remembered it being in the 70s. Nurse #20 said that Nurse #14 administered Narcan to Resident #20. Nurse #20 further stated she was not sure why EMS (Emergency Medical Services) was not notified, and she did not know at the time that EMS was supposed to be notified when Narcan was administered. Nurse #20 shared that she did not look at the order for Narcan because she was not the one who administered it to Resident #8. Nurse #20 recalled Resident #8's pupils being very pinpoint, and he was very lethargic on the day that he died but because Nurse #14 told her that Resident #8 was DNR (Do Not Resuscitate) and that there was nothing else they could do for him, she did not think about calling EMS. Nurse #20 stated she was not familiar with Narcan and had never given it before. She also did not receive training on Narcan administration at the facility prior to her working there. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow-up phone interview with Nurse #20 on [DATE] at 12:26 PM revealed that [DATE] was her very first day working at the facility as an agency nurse and she did not have access at the time to the clinical messaging platform that the facility used to contact the on-call providers. Nurse #20 stated that she did not think about calling the on-call provider because she thought that Nurse #14 took over Resident #8's care when she gave him the Narcan. Nurse #20 explained that during this incident, she was still trying to get her medication pass done, and she thought Nurse #14 was going to take care of Resident #8. Nurse #20 further shared that she asked Nurse #14 if they needed to send Resident #8 to the hospital, but Nurse #14 told her no, and that they were not going to do anything for Resident #8 because he was DNR. Nurse #20 confirmed that Resident #8 was somewhat more responsive after the two doses of Narcan, but she was not familiar with him because this was her first time taking care of Resident #8, so she did not know what was normal for him. Resident #8 stayed in bed asleep, and his oxygen saturation went up a little, but he got worse in the afternoon when he became lethargic and unresponsive with no heart rate and no breathing. She notified Nurse #14 but again Nurse #14 told her there was nothing they could do for Resident #8. Nurse #20 stated she could not remember why she did not send Resident #8 to the hospital after he received the two doses of Narcan. She did not think of administering the Narcan again and did not think about calling 911. She further shared that she had never administered Narcan before which was why she asked for help from Nurse #14. The interview further revealed that Nurse #20 started as an agency nurse on [DATE] and later signed a contract with the facility. Nurse #20 stated she received no orientation prior to working at the facility because agency staff did not receive orientation. Nurse #20 stated that she was only given an orientation packet and was asked to sign a checklist, but she did not have time to read over the material before she started working on the floor on [DATE]. Nurse #20 also stated she was not familiar with the facility's policy regarding the administration of Narcan. She further stated that she was not sure how to notify an on-call provider for the facility if needed during a medical emergency. Nurse #20 explained that she did not receive any training from the facility regarding emergency procedures. A phone interview with Nurse #14 on [DATE] at 10:56 AM revealed she was working as the weekend supervisor on [DATE] when Nurse #20 alerted her about Resident #8 being unresponsive. Nurse #14 stated that she administered two doses of Narcan to Resident #8 to try to get him to wake up because she suspected that he might have overdosed from medications. Nurse #14 said she thought Nurse #20 spoke with the on-call provider while she was busy taking care of Resident #8. Nurse #14 further stated that Nurse #20 told her that she had called the doctor, and she thought that Nurse #20 had also called 911. Nurse #14 commented that she thought Nurse #20 had called 911 because Resident #8 was Nurse #20's resident, and after giving Resident #8 the two doses of Narcan, Nurse #14 went back to the other side of the building. Nurse #14 stated that she knew this was Nurse #20's first day working at the facility, and that she was supposed to monitor Nurse #20, but she was also busy on another hall. Nurse #14 stated she did not think she needed to call 911 because Resident #8 responded to the Narcan doses, and he was DNR. Nurse #14 further stated that she was not familiar with the facility's policy for Narcan administration, and had not received training on how to administer Narcan. She found out later around 2:00 PM that Resident #8 took a turn for the worse but because the Assistant Director of Nursing (ADON) told her that morning after she gave him Narcan that Resident #8 was DNR, and that he was dying, she didn't think there was anything else she should have done. During a follow-up interview with Nurse #14 on [DATE] at 8:32 AM, Nurse #14 stated she started as the weekend supervisor on [DATE], but she did not get orientation on her job responsibilities. Nurse #14 stated she remembered signing a job description, but she did not receive formal training on what she needed to do as the weekend supervisor. Nurse #14 also stated that she was the nurse who had been at the facility the longest and she had worked previously as a supervisor nine years ago. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A joint interview with the Director of Nursing (DON) and the ADON on [DATE] at 2:34 PM revealed agency nurses who worked per diem received an orientation packet while agency nurses who signed a contract with the facility received at least one shift of orientation while working with another nurse. The DON stated Nurse #20 started as a per diem agency nurse so she would not have gotten a shift orientation before she worked on the floor. The Human Resources Director usually reviewed the packet with agency nurses prior to them working, but Nurse #14 should have monitored Nurse #20 since it was her first day working at the facility, and it was on a weekend. The ADON further stated that Nurse #14 did not get training as a supervisor, and they were not sure whether she used to be supervisor. The DON stated Nurse #14 was expected to read her job description and that they went over her responsibilities with her as a team. An interview with the Administrator on [DATE] at 4:34 PM revealed they put agency nurses through an onboarding list. Nursing went over with them the review of the medication carts. The Administrator stated that typically when agency nurses started, they came in with the knowledge on how to do their job while receiving monitoring from administrative staff. Nurse #14 had worked as a charge nurse, as a Unit Manager, and as the Director of Nursing before at the facility. The Administrator was notified of immediate jeopardy on [DATE] at 10:54 AM. 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 ensure nursing staff were trained and competent in responding to medical emergencies, activating emergency response, and notifying medical providers for Resident #8 who received two doses of Narcan on [DATE] at 9:34 AM and 9:54 AM, with positive response, for suspicion of drug overdose. All residents who use opioid medications are at risk of overdose and may be subject to the need for Narcan administration and emergency response. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The facility needs to have a system in place to provide training and verify competencies for nurses related to responding to medical emergencies, medical provider notification and activation of emergency response. The facility continues to employ agency nurses without providing orientation and training prior to providing care to the residents. * An audit was completed by [DATE] by the Nurse Consultant on the number of residents who are prescribed opioid medication, which will include residents that have a diagnosis of opioid abuse disorder that do not have a scheduled or prn opioids. * The Director of Nursing/Assistant Director of Nursing (designee) has re-educated the licensed nursing staff on medical emergencies and emergency activation response per physician orders on [DATE]. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The actions the Director of Nursing/ Assistant Director of Nursing (designee) will take to ensure the nurses have activated the emergency response as indicated in the physician's orders on the administration of Narcan is the DNS will review the 24-hour report on a daily basis for appropriate activation of the emergency response. Feedback will be provided by the DNS addressing any challenges or barriers, which can require re-education if needed. * Agency licensed nurses working at the facility will receive education on medical emergencies and activation of the emergency response by the DNS/Assistant Director of Nursing (designee). * Licensed nursing staff, including agency staff that are not available on or before [DATE] will not be scheduled until the education has been completed. The Director of Nursing/Assistant Director of Nursing (designee) will provide education on medical emergencies, medical provider notification, and activation of emergency response for the nursing staff unavailable after [DATE] before they start the shift. * The nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system which is denoted in the revised Narcan Administration Policy [DATE]. * The facility will initiate Mock Medical Emergencies Drills on each shift weekly x 4 weeks, and then ongoing monthly upon completion of the licensed nursing education. The first drill took place [DATE]. The DNS and/or the ADNS will critique the drill denoting areas in need of improvement. The alleged date of immediate jeopardy removal is [DATE]. The credible allegation for the immediate jeopardy removal was validated on [DATE] with a removal date of [DATE]. A review of in-service education records dated [DATE] revealed education was provided to nurses including agency nurses on the activation of emergency response upon administration of Narcan, and ensuring the medical provider has been notified of any resident receiving Narcan and activating EMS per physician orders. Interviews with the nursing staff including agency nurses revealed they had been educated on activating EMS and notifying the medical provider of any resident who receives Narcan for suspected overdose. The nurses including agency nurses stated they received education on medical emergencies and activation of the emergency response. Interviews with staff confirmed a mock medical emergency drill was conducted on [DATE] and [DATE] where the nursing staff initiated emergency response and notified the doctor of a suspected drug overdose. The audit completed by the Nurse Consultant on [DATE] was reviewed. All residents identified as having orders for Narcan administration had notification of medical providers added to the Narcan order. A review of the revised policy for Narcan Administration dated [DATE] indicated that the nurse who responds to the suspected overdose will direct another staff member to activate the emergency response system. The facility's date of immediate jeopardy removal of [DATE] was validated.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on record reviews, staff, family, Pharmacist and Medical Director interviews the facility failed to obtain an antianxiety medication from the pharmacy which caused a resident to miss 3 doses of antianxiety medication for 1 of 5 residents (Resident #7) reviewed for medication errors. This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down. The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses including anxiety disorder. Review of Resident #7's physician orders revealed an order dated 04/30/23 for lorazepam one milligram (mg) every twelve hours as needed for anxiety and an order dated 05/01/23 for lorazepam one mg by mouth three times a day for anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact, had unclear speech, was usually able to make himself understood, and was able to understand others. The MDS also indicated Resident #7 received antianxiety medication during the lookback period. Resident #7's Medication Administration Record (MAR) for April 2024 revealed the doses of lorazepam one mg scheduled for 8:00 AM, 2:00 PM, and 9:00 PM on 04/25/24 were not initialed as administered. An interview with Nurse #17 on 05/08/24 at 1:58 PM revealed she was assigned to care for Resident #7 on 04/25/24 on the 7:00 AM to 11:00 PM shift and was notified in report the morning of 04/25/24 that Resident #7 was out of his scheduled lorazepam 1 mg. Nurse #17 stated Resident #7 had a physician order for prn (meaning as needed) lorazepam one mg every twelve hours, but he was out of that medication also and there was none in the emergency back-up medication dispenser. Nurse #17 explained when she completed her 8:00 AM medication pass, she called pharmacy to ask when Resident #17's lorazepam would be available and was told Resident #17 needed a new prescription for the medication. She stated she notified the ADON and DON that Resident #17 was out of lorazepam one mg, had missed two scheduled doses of lorazepam on 04/25/24, and needed a new prescription to be sent to the pharmacy. Nurse #17 stated she was notified by the ADON that Resident #17's lorazepam would arrive from the pharmacy in the night delivery. She stated the lorazepam did not arrive from pharmacy before she left the night of 04/25/24. An interview with NA #7 on 05/10/24 at 8:10 AM revealed she cared for Resident #7 on 04/25/24 on the 7:00 AM to 7:00 PM shift. She stated Resident #7 did not receive his lorazepam that day and was anxious all day. NA #7 explained Resident #7 repeatedly rang his call light to request his lorazepam, was sweating and shaking, and requested she text his mom and ask her to come to the facility on [DATE]. She stated she texted Resident #7's mom as he requested and tried to reassure Resident #7 that Nurse #17 was working on getting his medication throughout her shift. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	A telephone interview with Resident #7's mother on 05/06/24 at 11:02 AM revealed 2 nurse aides (NAs) called her on 04/25/24 from Resident #7's cell phone per his request (she was unsure of the exact time of the call) because he had not received his lorazepam. She stated the NAs informed her Resident #7 was in a panic and he wanted her to come to the facility to help him calm down. Resident #7's mother stated she came to the facility to check on Resident #7 and he was panicky and did not want her to leave. She stated she spoke with Nurse #17 on 04/25/24 and the nurse confirmed Resident #7 was out of lorazepam and she was trying to get the medication from pharmacy. Resident #7's mother stated she later found out Resident #7 did not receive any doses of lorazepam on 04/25/24. A telephone interview with the Medical Director on 05/07/24 at 3:06 PM revealed when residents ran out of medication, the on-call Nurse Practitioner (NP) was notified of the need for a prescription refill and a temporary prescription was issued until the regular delivery shipment of medications was received from the pharmacy. He stated he was not notified Resident #7 missed 3 scheduled doses of lorazepam on 04/25/24 and confirmed missing the medication doses would result in an increase in anxiety. A joint interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 05/08/24 at 1:12 PM revealed Nurse #17 notified the ADON on 04/25/24 that Resident #7 was out of his scheduled lorazepam and needed a new prescription. The ADON explained she logged onto the online forum the facility used to communicate with providers and saw multiple prescription refill requests for Resident #7's lorazepam had been requested and the providers responded that the prescription had been sent to pharmacy electronically. The ADON stated she called the pharmacy and asked for Resident #7's lorazepam to be sent to the facility stat (immediately) and she understood the medication would arrive as soon as possible. The ADON stated stat orders did not mean the same thing in long term care as in acute care, but she thought the medication would arrive sooner than the scheduled pharmacy delivery that occurred nightly between 10:30 PM and midnight. When the ADON and DON were asked why they did not request a prescription be sent electronically by the provider to a local pharmacy and picked up on 04/25/24, they explained they were new to their roles and did not know that was an option. They stated in hindsight, they would have asked the provider to send an electronic prescription for the lorazepam to a local pharmacy and staff would pick it up rather than waiting on the medication to arrive from the facility pharmacy located in Hickory, NC. An interview with the Pharmacist on 05/08/24 at 5:18 PM revealed the last refill request from the facility for lorazepam one mg for Resident #7 prior to 04/25/24 was on 03/15/24. She stated on 03/17/24 sixty lorazepam one mg tablets were delivered to the facility for Resident #7. The Pharmacist confirmed she had no record of a stat request for lorazepam tablets from the facility on 04/25/24 for Resident #7. An interview with the Administrator on 05/10/24 at 4:15 PM revealed it was her understanding that nursing staff had a difficult time getting Resident #7's prescription refilled for lorazepam and when the prescription was obtained and sent to pharmacy, the medication did not arrive in the pharmacy delivery (she could not recall the date). She confirmed Resident #7 missed 3 scheduled doses of lorazepam on the day in question. The Administrator stated in hindsight the Medical Director should have been contacted and a prescription for lorazepam called in to a local pharmacy and picked up, so the resident did not have to miss multiple doses of scheduled medication.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on record review and staff, Medical Director, and family interviews the facility failed to ensure a resident was free of significant medication errors due to failing to administer three scheduled lorazepam (antianxiety medication) doses. The deficient practice was for 1 of 5 residents reviewed for medication errors (Resident #7). This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down. The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses including anxiety disorder. Review of Resident #7's physician orders revealed an order dated 04/30/23 for lorazepam one milligram (mg) every twelve hours as needed for anxiety and an order dated 05/01/23 for lorazepam one mg by mouth three times a day for anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact, had unclear speech, was usually able to make himself understood, and was able to understand others. Resident #7's care plan last updated 03/19/24 revealed he used antianxiety medications related to anxiety disorder. Interventions included administering antianxiety medications as ordered by the physician, and monitoring/recording the occurrence of target symptoms. Resident #7's Medication Administration Record (MAR) for April 2024 revealed the doses of lorazepam one mg scheduled for 8:00 AM, 2:00 PM, and 9:00 PM on 04/25/24 were not initialed as administered. An interview with Nurse #17 on 05/08/24 at 1:58 PM revealed she was assigned to care for Resident #7 on 04/25/24 on the 7:00 AM to 11:00 PM shift and was notified in report the morning of 04/25/24 that Resident #7 was out of his scheduled lorazepam 1 mg. Nurse #17 stated Resident #7 had a physician order for prn (meaning as needed) lorazepam one mg every twelve hours, but he was out of that medication also and there was none in the emergency back-up medication dispenser. Nurse #17 explained when she completed her 8:00 AM medication pass, she called pharmacy to ask when Resident #17's lorazepam would be available and was told Resident #17 needed a new prescription for the medication. She stated she notified the ADON and DON that Resident #17 was out of lorazepam one mg, had missed two scheduled doses of lorazepam on 04/25/24, and needed a new prescription to be sent to the pharmacy. Nurse #17 stated she was notified by the ADON that Resident #17's lorazepam would arrive from the pharmacy in the night delivery. She stated the lorazepam did not arrive from pharmacy before she left the night of 04/25/24. Nurse #17 confirmed Resident #7 was tense all day on 04/25/24, had episodes of crying throughout the day, repeatedly requested his lorazepam, and asked Nurse Aide (NA) #7 to call his mom multiple times throughout the day. She stated she reassured Resident #7 throughout her shift that she was working on obtaining the medication from pharmacy. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview with NA #7 on 05/10/24 at 8:10 AM revealed she cared for Resident #7 on 04/25/24 on the 7:00 AM to 7:00 PM shift. She stated Resident #7 did not receive his lorazepam that day and was anxious all day. NA #7 explained Resident #7 repeatedly rang his call light to request his lorazepam, was sweating and shaking, and requested she text his mom and ask her to come to the facility on [DATE]. She stated she texted Resident #7's mom as he requested and tried to reassure Resident #7 that Nurse #17 was working on getting his medication throughout her shift. A telephone interview with Resident #7's mother on 05/06/24 at 11:02 AM revealed 2 nurse aides (NAs) called her on 04/25/24 from Resident #7's cell phone per his request (she was unsure of the exact time of the call) because he had not received his lorazepam. She stated the NAs informed her Resident #7 was in a panic and he wanted her to come to the facility to help him calm down. Resident #7's mother stated she came to the facility to check on Resident #7 and he was panicky and did not want her to leave. She stated she spoke with Nurse #17 on 04/25/24 and the nurse confirmed Resident #7 was out of lorazepam and she was trying to get the medication from pharmacy. Resident #7's mother stated she later found out Resident #7 did not receive any doses of lorazepam on 04/25/24. A telephone interview with the Medical Director on 05/07/24 at 3:06 PM revealed when residents ran out of medication, the on-call Nurse Practitioner (NP) was notified of the need for a prescription refill and a temporary prescription was issued until the regular delivery shipment of medications was received from the pharmacy. He stated he was not notified Resident #7 missed 3 scheduled doses of lorazepam on 04/25/24 and confirmed that would be a significant medication error for Resident #7 and would result in an increase in anxiety. A joint interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 05/08/24 at 1:12 PM revealed Nurse #17 notified the ADON on 04/25/24 that Resident #7 was out of his scheduled lorazepam and needed a new prescription. They stated in hindsight, they would have asked the provider to send an electronic prescription for the lorazepam to a local pharmacy and staff would pick it up rather than waiting on the medication to arrive from the facility pharmacy located in Hickory, NC. An interview with the Administrator on 05/10/24 at 4:15 PM revealed it was her understanding that nursing staff had a difficult time getting Resident #7's prescription refilled for lorazepam and when the prescription was obtained and sent to pharmacy, the medication did not arrive in the pharmacy delivery (she could not recall the date). She confirmed Resident #7 missed 3 scheduled doses of lorazepam on the day in question. The Administrator stated in hindsight the Medical Director should have been contacted and a prescription for lorazepam called in to a local pharmacy and picked up, so the resident did not have to miss multiple doses of scheduled medication.

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	345302	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Health & Rehab of Sylva	417 Cloverdale Road Sylva, NC 28779

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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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 41069 Based on record review, interviews with staff and the Medical Director (MD), the facility failed ensure the MD was aware of resident care policies related to the administration of Naloxone or Narcan (a medication designed to rapidly reverse opioid overdose in an emergency situation). This deficient practice had the potential to affect all residents with active orders for Narcan. The findings included: A review of the Medical Director/Attending Physician job description signed by the facility's Medical Director (MD) on 2/1/24 included the following under essential functions and responsibilities: Medical directorship functions include attending and participating in monthly quality assurance and process improvement meetings, participating in quality improvement initiatives, providing guidance to facility staff, overseeing clinical care plan, reviewing and revising (if necessary) facility's clinical guidelines, insuring compliance with state and federal regulations, training facility staff, and supervising facility clinical staff. An interview with the Medical Director (MD) on 5/8/24 at 10:21 AM revealed he started working at the facility as the Medical Director in February 2024. The MD stated that he was not familiar with the facility policy for Narcan. The MD stated that if the policy indicated for staff to notify Emergency Medical Services when administering Narcan, then the staff should have followed the policy. An interview with the Administrator on 5/22/24 at 4:35 PM revealed the current MD took over in mid-January 2024, and he had attended the QA (Quality Assurance) meetings, but he had not been to all of them. The Administrator stated that they discussed random facility policies during the QA meetings. She stated that she did not know that the MD did not know about the facility's Narcan policy, but she knew that he had just been notified of the updated Narcan policy after they discussed the issues identified during the current survey.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on observations, record reviews, an audio digital file, and interviews from resident, staff, visitor, family, Pharmacist, and Medical Director, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification surveys conducted on 4/29/21 and 1/20/23 and the complaint investigation surveys conducted on 9/29/21, 1/6/22, 6/7/23, 10/18/23, 11/21/23, 11/30/23, and 12/7/23. This was for seven repeat deficiencies that were cited in the areas of visitation rights, safe and comfortable environment, notification of changes, quality of care, accident hazards, pharmacy services and significant medication errors. Visitation rights was originally cited on 9/29/21 during a complaint investigation survey, and subsequently recited during the complaint investigation survey completed on 5/22/24. Safe and comfortable environment was originally cited on 6/7/23 during a complaint investigation survey and subsequently recited during the complaint investigation survey completed on 5/22/24. Notification of changes was originally cited on 1/6/22 during a complaint investigation survey, and subsequently recited during the complaint investigation surveys completed 6/7/23 and 5/22/24. Quality of care was originally cited on 12/7/23 during a complaint investigation survey, and subsequently recited during the complaint investigation survey completed on 5/22/24. Accident hazards was originally cited on 1/20/23 during the recertification and complaint investigation survey, and subsequently recited during the complaint investigation surveys completed on 11/21/23, 11/30/23, and 5/22/24. Pharmacy services was originally cited on 4/29/21 during the recertification and complaint investigation survey, and subsequently recited during the complaint investigation surveys completed on 6/7/23, 11/30/23, and 5/22/24. Significant medication errors was originally cited on 6/7/23 during a complaint investigation survey, and subsequently recited during the complaint investigation surveys on 10/18/23, and 5/22/24. The continued failure of the facility during ten federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referred to: F563 - Based on observations, record reviews, an audio digital file, and interviews from resident, staff, and visitor interviews, the facility failed to allow unrestricted visitation by limiting visitation for 1 of 1 resident reviewed for visitation (Resident #3). During a complaint investigation survey on 9/29/21, the facility imposed a restricted visitation schedule that limited indoor and outdoor visitation of family and friends to 30 minutes per visit. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F580 - Based on record reviews, and interviews with resident, staff and the Medical Director, the facility failed to notify a medical provider of significant changes in a resident's condition (Resident #8) who was observed to be unresponsive to painful stimuli, having low oxygen saturation level and pupil constriction. Nurse #14 suspected drug overdose and administered one dose of Naloxone, also known as Narcan (a medication used to rapidly reverse opioid overdose in an emergency situation) on 3/2/24 at 9:34 AM and an additional dose at 9:54 AM without notifying a medical provider. Resident #8 responded temporarily to the Narcan doses but at 3:50 PM, he was observed with no heart rate or respiratory rate and was pronounced dead. In addition, the facility failed to notify the Guardian after a resident (Resident #6) tested positive for tetrahydrocannabinol (THC - a compound found in cannabis/marijuana plants). This deficient practice affected 2 of 3 residents reviewed for notification of changes. During a complaint investigation survey on 6/7/23, the facility failed to notify the physician levetiracetam (an anticonvulsant medication) was not administered as scheduled when the resident was out of the facility. During a complaint investigation survey on 1/6/22, the facility failed to notify a resident's representative of left shoulder x-rays that were obtained and a subsequent transfer to the hospital. F684 - Based on record reviews, and interviews with staff and the Medical Director, the facility failed to initiate emergency medical services for symptoms of a drug overdose. Resident #8 was slumped over, non-responsive with constricted pupils and impaired respiration. Resident #8 was observed by a facility staff member with no heart rate or respiratory rate and was pronounced dead on 3/2/24 at 3:50 PM. This deficient practice affected 1 of 3 residents reviewed for quality of care. During a complaint investigation survey on 12/7/23, the facility failed to complete wound care as ordered by the wound care provider. F689 - Based on observation, record reviews and visitor, family, staff, and Medical Director interviews, the facility failed to enforce their smoking policy, monitor a resident who had a history of non-compliance with the smoking policy for storage of smoking materials, and implement interventions to prevent a resident from vaping in his room with his oxygen on and while his roommate (Resident #6) was in the room. Resident #8, who was on oxygen, was found to have a vape pen in his possession on 2/2/24, 2/16/24, and 3/1/24, and was observed vaping while on oxygen on 3/1/24. An electronic cigarette or vape pen (vaporizer) is a device that simulates tobacco smoking. It contains a heating element which reaches high temperatures and can ignite nasal cannula with oxygen flowing. Vaping while on oxygen placed Resident #8 and Resident #6 at increased risk for fire and combustion. This posed a high likelihood of serious injury to all residents. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility also failed to prevent a resident with moderate cognitive impairment, a history of wandering and exit seeking behaviors, delusional behavior, and delusions from exiting the facility unsupervised and without staff knowledge (Resident #1). Staff interviews revealed an emergency exit door alarm in hallway of the 200 unit sounded around shift change (7:00 AM) on 2/20/24 and staff disarmed the alarm without initiating a Code [NAME] (the facility elopement protocol), without conducting a full resident head count to ensure all residents were in the facility at the time, and without conducting a thorough search of the area which was accessible from the exit. Between 7:05 AM and 7:10 AM, a visitor arrived at the facility and found Resident #1 outside, unsupervised, wearing a thin night gown, holding multiple pieces of mail, without shoes, and wearing socks on her feet. The resident was discovered at the front of the facility approximately 120 yards from the 200 hall exit door. The visitor indicated Resident #1 appeared cold, so he had the resident sit in his car with the heat on until the transportation aide arrived at the facility to open the facility door around 7:30 AM. There was a high likelihood of serious injury from falls and hypothermia as temperatures were recorded at 23 degrees Fahrenheit at the approximate time Resident #1 was found outside. In addition, the facility failed to protect a resident from exposure to an illegal substance. As a result, Resident #6 was found to have experienced altered mental status, impaired physical mobility, and slurred speech. The drug screening test conducted by Nurse #2 confirmed Resident #6 was positive for tetrahydrocannabinol (THC- a compound found in cannabis/marijuana plants). These deficient practices affected 3 of 5 residents reviewed for risk for accidents. During a complaint investigation survey on 11/30/23, the facility failed to use a mechanical lift to transfer a non-ambulatory resident. During a complaint investigation survey on 11/21/23, the facility failed to prevent a resident with severe cognitive impairment and a history of wandering and exit seeking behaviors, from exiting the facility unsupervised and without staff knowledge. During a recertification and complaint investigation survey on 1/20/23, the facility failed to conduct smoking assessment periodically. F755 - Based on record reviews, staff, family, Pharmacist and Medical Director interviews the facility failed to obtain an antianxiety medication from the pharmacy which caused a resident to miss 3 doses of antianxiety medication for 1 of 5 residents (Resident #7) reviewed for medication errors. This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down. During a complaint investigation survey on 11/30/23, the facility failed to obtain a controlled pain medication from the pharmacy. During a complaint investigation survey on 6/7/23, the facility failed to acquire medications ordered for administration resulting in multiple doses of the prescribed medication being missed. During a recertification and complaint investigation survey on 4/29/21, the facility failed to have 2 nurses, or a nurse and a medication aide sign the narcotic count card. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F760 - Based on record review and staff, Medical Director, and family interviews the facility failed to ensure a resident was free of significant medication errors due to failing to administer three scheduled lorazepam (antianxiety medication) doses. The deficient practice was for 1 of 5 residents reviewed for medication errors (Resident #7). This failure resulted in Resident #7 experiencing feelings of panic, sweatiness, crying, shaking and asking for assistance from family to calm down. During a complaint investigation survey on 10/18/23, the facility failed to administer a short-acting insulin as ordered by the physician. During a complaint investigation survey on 6/7/23, the facility failed to prevent a significant medication error by not administering 12 doses of Levetiracetam (an anticonvulsant medication) as ordered by the physician. During an interview conducted on 04/24/24 at 3:28 PM, the Administrator acknowledged that the facility had repeated citations. The Administrator stated the facility's QAPI committee had met each time after a state survey, and at least quarterly or as needed, to discuss plans of correction, implement changes, conduct training, and carry out monitoring and audit, as needed. She indicated the facility had done due diligence at its best to remain in compliance. She attributed the repeated citations to frequent changes in management staff and maintenance staff, and lack of sense of urgency by the nursing staff.