STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nrsg & Rehab Cntr of Southport LLC	630 Fodale Avenue Southport, NC 28461

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on observations, record review, and resident and staff interviews the facility failed to administer medications on time as prescribed by the physician for 1 of 1 residents reviewed. (Resident #7) Findings included: Resident #7 was admitted to the facility on [DATE]. Diagnoses included, in part, schizophrenia, anxiety, dementia with behavioral disturbance, and constipation. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #7 was cognitively intact and received antipsychotics and antianxiety medications. An interview was conducted with Resident #7 on 03/04/24 at 1:00 PM. Resident #7 reported she did not receive her medications on time and at times the nursing staff would wake her up after 10:00 PM to administer her medications that were due at 8:00 PM. Resident #7 stated she had told the nursing staff she wanted her medications at 8:00 PM so she could go to bed and not be woken up. Resident #7 stated she had received her 8:00 PM medications as late as 2:00 in the morning. Resident #7 stated she did not have any increased anxiety, delayed bowel movements or increased behaviors as a result of receiving the medications late, but added, she wanted them when they were scheduled. Review of the physicians' orders revealed an order written on 10/03/20 for Senna Plus 8.6-50 milligrams (mg) give 2 tablets one time a day for constipation, an order written on 10/14/21 for Risperidone (an antipsychotic) tablet 0.5 mg give one tablet at bedtime, and an order written on 07/31/23 for Klonopin (an antianxiety) 0.5 mg give one tablet two times a day for anxiety. Review of the Medication Administration Record for February 2024 revealed the medications (Senna Plus, Risperidone, and Klonopin) were all scheduled to be given at 8:00 PM. Review of the Medication Administration Audit Report for February 1 through February 29, 2024, revealed the bowel medication, the antipsychotic medication, and the antianxiety medication were administered later than 8:00 PM. The audit report indicated the scheduled time which was 8:00 PM and the administration time. The following included the dates the medications were administered late per the actual administration time: 02/01/24 medications administered at 11:41 PM by Medication Aide (MA) #5 (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/03/24 medications administered at 10:30 PM by MA #1 02/04/24 medications administered at 10:04 PM by MA #1 02/06/24 medications administered at 10:04 PM by MA #1 02/07/24 medications administered at 10:15 PM by MA #5 02/09/24 medications administered at 12:30 AM by MA #1 02/13/24 medications administered at 10:40 PM by MA #1 02/14/24 medications administered at 12:56 AM by MA #5 02/15/24 medications administered at 1:39 AM by Nurse #4 02/17/24 medications administered at 1:46 AM by MA #1 02/19/24 medications administered at 10:27 PM by MA #1 02/20/24 medications administered at 10:50 PM by MA #1 02/22/24 medications administered at 10:58 PM by MA #1 02/24/24 medications administered at 10:32 PM by MA #1 02/27/24 medications administered at 10:49 PM by MA #1 Review of the Medication Administration Record for March 2024 revealed the medications (Senna Plus, Risperidone, and Klonopin) were all scheduled to be given at 8:00 PM. Review of the Medication Administration Audit Report for March 1 through March 6, 2024, revealed the bowel medication, the antipsychotic medication, and the antianxiety medication were administered later than 8:00 PM. The audit report indicated the scheduled time which was 8:00 PM and the administration time. The following included the dates the medications were administered late per the actual administration time: 03/03/24 medications administered at 10:20 PM by MA #1 03/04/24 medications administered at 10:15 PM by MA #1 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with MA #1 via phone on 03/06/24 at 3:15 PM. MA#1 revealed she worked on the 500 hall where Resident #7 resided and the 300 hall from 7:00 PM to 7:00 AM. She stated she could not remember why she was late administering the medications to Resident #7. MA #1 added, things happen and she would fall behind. She stated she did not ask her nurse to help her when she was getting behind because she did not want to bother the nurse. MA #1 stated the medication time was 8:00 PM and the nursing staff had the flexibility to give the medications one hour before or one hour after the medications were due. MA #1 confirmed the times she gave the medications were much later than the prescribed allowable time. MA #1 stated she did not recall Resident #7 expressing to her that she wanted her medications at 8:00 PM. An interview was conducted with MA #5 via phone on 03/07/24 at 3:00 PM. MA #5 reported her routine when she came on shift was to read through the progress notes and she would start her medication pass about 8:00 - 8:30 PM. She stated she started on the 500 hall were Resident #7 resided and would usually finish about 10:00 - 10:30 PM. MA #5 stated she did not know why the medications were passed so late to Resident #7 on 02/01, 02/07 and 02/14/24. MA #5 stated Resident #7 had expressed to her to that she wanted her medications before she went to bed and not at 1:00 AM. MA #5 stated she did not reach out to the nurse on those nights to let her know she was behind on passing medications and she should have. An interview was attempted with Nurse #4 via phone on 03/07/24 at 11:00 AM. There was no response. An interview was conducted with the Physician on 03/07/24 at 12:10 PM. The Physician stated she would expect the nursing staff to administer the medications when they were due or within the hour before the medication was due or the hour after. An interview was conducted with the Director of Nursing (DON) on 03/07/24 at 2:30 PM. The DON reported she felt the medications aides needed to work on their time management and that the medication pass had been significantly decreased when the new physician had done an audit and discontinued several medications for several residents to decrease the medication pass time and unnecessary medications. The DON stated the medication aides were expected to start on the 500 hall and then finish on the 300 hall. She stated there were about 29 residents between the two halls and the medications aides should have been able to administer the medications at the prescribed time or no later than an hour after the prescribed time.

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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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and staff interview the facility failed to complete comprehensive assessments within the 14-day required timeframe for 2 of 2 residents reviewed for comprehensive Minimum Data Set (MDS) assessments (Resident #290 and Resident #291). Findings included: 1. Resident #290 was admitted to the facility on [DATE]. Resident #290's admission Minimum Data Set (MDS) dated [DATE] was noted as in progress as of 3/7/24. An interview was conducted with the MDS Nurse on 3/07/24 at 2:41 PM. The MDS Nurse stated the workload had increased with a lot of residents discharging and returning and she had more difficulty keeping up with the workload. The MDS Nurse stated she was aware of the timelines for completion of the MDS assessments and had completed assessments late recently. MDS Nurse stated she was trying to get caught up. An interview with the Administrator on 3/07/24 at 3:10 PM revealed she expected that MDS assessments be completed in a timely manner. 2. Resident #291 was admitted to the facility on [DATE]. Resident #291's 2/21/24 admission Minimum Data Set assessment was completed on 2/21/24. An interview was conducted with the MDS Nurse on 3/07/24 at 2:41 PM. The MDS Nurse stated the workload had increased with a lot of residents discharging and returning and she had more difficulty keeping up with the workload. The MDS Nurse stated she was aware of the timelines for completion of the MDS assessments and had completed assessments late recently. MDS Nurse stated she was trying to get caught up. An interview with the Administrator on 3/07/24 at 3:10 PM revealed she expected that MDS assessments be completed in a timely manner.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, observation, and resident, staff and physician interviews, the facility failed to obtain an appointment with a retinol specialist for treatment of visual impairment for 1 of 1 residents (Resident #9) reviewed for vision. Findings included: Resident #9 was admitted to the facility on [DATE] with a diagnosis which included dry eye syndrome. Review of Resident #9's electronic health record revealed a 10/17/23 vision consult which indicated Resident #9 had gradual blurry vision with the left eye greater than the right. The plan of care indicated Resident #9 was to have a referral to a retinol specialist for treatment with an appointment to be scheduled within 2-3 weeks. Review of Resident #9's electronic health record revealed a 10/17/23 optometry order form indicated a referral to a retinol specialist was required for evaluation of left eye advanced macular degeneration, a disease that causes vision loss. Review of Resident #9's 2/13/24 quarterly Minimum Data Set assessment revealed resident had adequate vision, corrective lenses were not used, and was cognitively intact. Observation of Resident #9 on 3/4/24 at 3:25 PM revealed resident sitting on the side of the bed with mail in her hands, glasses on and her call bell was activated. An interview was conducted with Resident #9 on 3/4/24 at 3:28 PM. Resident #9 stated she needed to see a vision specialist and the appointment was supposed to have been scheduled months ago. Resident #9 revealed she had trouble with vision in her left eye and was unable to see. Resident #9 indicated she activated her call bell to request assistance with reading her mail. Review of Resident #9's progress notes as of 3/5/24 revealed no evidence that the appointment with the retinol specialist was scheduled or completed. Review of Resident #9's consult notes as of 3/5/24 revealed no evidence that the resident was evaluated by the retinol specialist. Interview on 3/6/24 at 12:10 PM with the Transporter/Appointment Scheduler revealed she was in the position since September 2023. The Transporter/Appointment Scheduler stated she was responsible for scheduling appointments for the resident after she received a referral from the nurses. The Transporter/Appointment Scheduler stated she scheduled the appointments and informed the resident and family of the date and time. The Transporter/Appointment Scheduler stated she thought she recalled the Nurse Practitioner said she was waiting for the resident to be seen by the vision clinic that visits the facility. The Transporter/Appointment Scheduler stated the vision clinic only visits the facility once per year. The Transporter/Appointment Scheduler stated she did not recall receiving a referral for an appointment with a retinol specialist. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/6/24 at 1:15 PM with the Director of Nursing (DON) revealed Medical Records received the report from the optometry appointment in October and uploaded it to Resident #9's medical record. Medical Records had not provided the Nurse Practitioner (NP) with the report for review. The DON stated the NP or physician was not made aware of the results of Resident #9's optometry appointment in October or the recommendation for the referral to a retinol specialist. The DON stated she was not aware of the results of the appointment in October or the referral. The DON stated an appointment was made today with the retinol specialist for 4/9/24 at 12:40 PM. Interview on 3/7/24 at 10:50 AM with the physician revealed she was just made aware that the appointment with the retinal specialist had not been scheduled as ordered on the consult report. The physician stated it would not cause resident harm by not obtaining the appointment with the retinol specialist sooner, but it was a system process error.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observations, record review, staff, and Physician interviews the facility failed to clarify a medication order prescribed for hypotension (low blood pressure) to include hold parameters if the systolic blood pressure was greater than 120 mm/hg (millimeters of mercury). This resulted in a resident (Resident #61) receiving 59 additional doses of the medication. There was no significant outcome from receiving the medication. This occurred for 1 of 3 residents reviewed for medication administration. Findings included. Resident #61 was admitted to the facility on [DATE] with diagnoses included in part; hypertensive chronic kidney disease with end stage renal disease, dependence on dialysis, and hypotension. A physicians order dated 05/03/23 for Resident #61 revealed Midodrine 10 milligrams (prescribed to treat hypotension which works by constricting the blood vessels causing increased blood pressure). Give 1 tablet by mouth three times a day for hypotension. Hold if systolic blood pressure is greater than 120 mm/hg. Review of the Medication Administration Record (MAR) for Resident #61 from 05/03/23 through 10/23/23 revealed Midodrine was administered as prescribed. Review of a hospital discharge summary dated 10/27/23 for Resident #61 revealed Midodrine oral tablets 10 mg (milligrams). Give 1 tablet by mouth three times a day for hypotension if systolic blood pressure is greater than 120 mm/hg. There was no hold parameter. Review of the Medication Administration Record (MAR) for Resident #61 dated November 2023 revealed Midodrine oral tablets 10 mgs. Give 1 tablet by mouth three times a day for hypotension if systolic blood pressure is greater than 120 mm/hg. There was no hold parameter included on the MAR. Further review of the Medication Administration Record (MAR) for Resident #61 dated November 2023 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 11/01/23 a blood pressure recorded at 09:00 AM revealed 142/76 (systolic/diastolic). 11/01/23 a blood pressure recorded at 02:00 PM revealed 142/76. 11/02/23 a blood pressure recorded at 06:00 AM revealed 142/84. 11/03/23 a blood pressure recorded at 09:00 AM revealed 170/65. 11/03/23 a blood pressure recorded at 02:00 PM revealed 176/89. 11/03/23 a blood pressure recorded at 09:00 PM revealed 176/89. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/07/23 a blood pressure recorded at 09:00 AM revealed 133/72. 11/07/23 a blood pressure recorded at 02:00 PM revealed 122/64. 11/11/23 a blood pressure recorded at 06:00 AM revealed 122/58. 11/11/23 a blood pressure recorded at 02:00 PM revealed 122/58. 11/11/23 a blood pressure recorded at 09:00 PM revealed 130/79. 11/12/23 a blood pressure recorded at 02:00 PM revealed 172/95. 11/13/23 a blood pressure recorded at 06:00 AM revealed 152/97. 11/17/23 a blood pressure recorded at 02:00 PM revealed 139/66. 11/19/23 a blood pressure recorded at 02:00 PM revealed 167/105. 11/21/23 a blood pressure recorded at 02:00 PM revealed 152/78. 11/22/23 a blood pressure recorded at 06:00 AM revealed 144/72. 11/22/23 a blood pressure recorded at 04:00 PM revealed 148/78. 11/22/23 a blood pressure recorded at 09:00 PM revealed 148/78. 11/24/23 a blood pressure recorded at 04:00 PM revealed 128/70. 11/27/23 a blood pressure recorded at 06:00 AM revealed 147/84. 11/27/23 a blood pressure recorded at 04:00 PM revealed 129/78. 11/27/23 a blood pressure recorded at 09:00 PM revealed 132/86. 11/29/23 a blood pressure recorded at 06:00 AM revealed 138/78. Review of the Medication Administration Record (MAR) for Resident #61 dated December 2023 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 12/04/23 a blood pressure recorded at 04:00 PM revealed 141/76. 12/04/23 a blood pressure recorded at 09:00 PM revealed 141/76. 12/06/23 a blood pressure recorded at 06:00 AM revealed 141/76. 12/06/23 a blood pressure recorded at 04:00 PM revealed 128/98. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/08/23 a blood pressure recorded at 06:00 AM revealed 132/64. 12/08/23 a blood pressure recorded at 04:00 PM revealed 130/68. 12/11/23 a blood pressure recorded at 06:00 AM revealed 142/60. 12/13/23 a blood pressure recorded at 04:00 PM revealed 127/79. 12/13/23 a blood pressure recorded at 09:00 PM revealed 127/79. 12/15/23 a blood pressure recorded at 06:00 AM revealed 130/70. 12/20/23 a blood pressure recorded at 06:00 AM revealed 122/64. 12/20/23 a blood pressure recorded at 04:00 PM revealed 122/64. 12/27/23 a blood pressure recorded at 04:00 PM revealed 126/79. Review of the Medication Administration Record (MAR) for Resident #61 dated January 2024 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 01/01/24 a blood pressure recorded at 09:00 PM revealed 167/87. 01/03/24 a blood pressure recorded at 06:00 AM revealed 167/87. 01/05/24 a blood pressure recorded at 04:00 PM revealed 136/72. 01/08/24 a blood pressure recorded at 06:00 AM revealed 157/79. 01/08/24 a blood pressure recorded at 04:00 PM revealed 158/80. 01/10/24 a blood pressure recorded at 09:00 PM revealed 131/74. 01/12/24 a blood pressure recorded at 04:00 PM revealed 140/85. 01/15/24 a blood pressure recorded at 04:00 PM revealed 165/84. 01/15/24 a blood pressure recorded at 09:00 PM revealed 165/84. 01/17/24 a blood pressure recorded at 06:00 AM revealed 165/84. 01/19/24 a blood pressure recorded at 06:00 AM revealed 123/68. 01/24/24 a blood pressure recorded at 06:00 AM revealed 134/73. 01/29/24 a blood pressure recorded at 04:00 PM revealed 148/89. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/29/24 a blood pressure recorded at 09:00 PM revealed 148/89. Review of the Medication Administration Record (MAR) for Resident #61 dated February 2024 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 02/02/24 a blood pressure recorded at 06:00 AM revealed 141/82. 02/02/24 a blood pressure recorded at 09:00 PM revealed 147/77. 02/18/24 a blood pressure recorded at 06:00 AM revealed 140/80. 02/21/24 a blood pressure recorded at 06:00 AM revealed 152/95. 02/21/24 a blood pressure recorded at 09:00 PM revealed 146/68. 02/23/24 a blood pressure recorded at 09:00 PM revealed 155/77. 02/26/24 a blood pressure recorded at 06:00 AM revealed 155/77. Review of the Medication Administration Record (MAR) for Resident #61 dated March 2024 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 03/01/24 a blood pressure recorded at 4:00 PM revealed 146/87. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #61 was cognitively intact. She received Hemodialysis. During an interview with Resident #61 on 03/06/24 at 2:30 PM she indicated she was not aware of what times or dates the medication for low blood pressure was administered to her. She stated dialysis treatments took a lot out of her and she didn't feel well most days. She indicated she was not certain if receiving the Midodrine when it wasn't needed had any affect at all on her. During a phone interview on 03/06/24 at 02:53 PM Medication Aide #1 stated she routinely provided care to Resident #61. She stated she knew Midodrine was prescribed for low blood pressure. She stated she thought she held the medication if her blood pressure was over 120 but couldn't indicate what dates the medication was held. She stated she could have held the medication although documented she gave it. She indicated if it was signed that the medication was given, then she gave the medication in error. During an interview on 03/07/24 at 09:46 AM the Registered Nurse Supervisor stated Resident #61's order for Midodrine should have been clarified when it was transcribed from the hospital discharge summary on 10/27/23. She stated Resident #61 received dialysis and her medication times varied according to her dialysis schedule. She stated although her name was on the order entry following Resident #61's readmission she believed she only revised the order and was not the staff that entered the order. She could not determine who entered the initial order. She stated the Midodrine should have been clarified and hold parameters put in place but that was not done. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 03/07/24 at 12:00 PM Medication Aide #2 stated she routinely provided care to Resident #61. She stated she thought she held the medication at times. She indicated if the medication was administered when it wasn't needed then it was done in error. During a phone interview on 03/07/24 12:13 PM Medication Aide #8 stated she gave Midodrine to Resident #61 when her blood pressure was over 120 (mm/hg). She indicated that was how the order was written on the MAR. Attempts were made to contact Nurse #1 during the investigation. Nurse #1 was an agency nurse and was on duty during the dates and times the Midodrine was administered to Resident #61. There was no response. Attempts were made to contact agency Medication Aides #5 and #7 during the investigation. The Medication Aides were on duty during the dates and times the Midodrine was administered to Resident #61. There was no response. Medication Aide #6 who was on duty during the dates and times the Midodrine was administered to Resident #61 was no longer employed and no phone number was available. During an interview on 03/07/24 at 10:18 AM the Physician stated she was made aware of the Midodrine error this morning. She wrote a new order with hold parameters for blood pressures greater than 160/90. She indicated the medication was not needed if Resident #61's blood pressure was elevated. She stated the order should have been clarified and hold parameters accurate. She stated Resident #61 receiving Midodrine when it wasn't needed would have no significant effect on her and there had been no change in her condition. During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated medications were reviewed in their morning meetings. She indicated she was not aware that hold parameters were not clarified on the order for Resident #61. She stated the order was corrected today. She stated the order should have been clarified on readmission and administered per order.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observation, record review, staff, Nurse Practitioner, and Physician interviews the facility failed to follow the physicians order and provide sliding scale insulin at bedtime to a resident (Resident #18) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in the resident not receiving a total of 74 units of insulin from 01/12/24 through 03/04/24. There was no significant outcome. This occurred for 1 of 3 residents reviewed for medication administration. Findings included. Resident #18 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus. A care plan dated 08/23/23 revealed Resident #18 had diabetes with the risk for complications. The goal of care was to adequately manage her diabetes in order to minimize the risk for complications. Interventions included in part; to administer sliding scale insulin as ordered. The Minimum Data Set annual assessment dated [DATE] revealed Resident #18 was cognitively intact. She required limited assistance with activities of daily living. She received insulin. A physicians order dated 01/11/24 for Resident #18 revealed Novolog Injection Solution 100 units per milliliter: Inject as per sliding scale subcutaneously before meals for diabetes for blood glucose readings as follows: 000 - 199 administer 0 units; 200 - 250 administer 2 units; 251 - 300 administer 4 units; 301 - 350 administer 6 units; 351 - 400 administer 8 units; 401 - 450 administer 10 units; 451 - 1000 administer 10 units - recheck and notify the physician. A progress note dated 01/11/24 documented by the Nurse Practitioner revealed in part; plan to stabilize Resident #18's blood sugars which have been more elevated lately. Adding sliding scale insulin now four times a day in addition to her Lantus (long-acting insulin). A physicians order dated 01/12/24 revealed blood glucose checks before meals and at bedtime for diabetes please see sliding scale instructions. (continued on next page)

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	345373	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for Resident #18 dated January 2024 revealed Novolog sliding scale insulin was administered as needed before meals. Novolog sliding scale insulin was not administered at bedtime as needed for blood glucose greater than 200 mg/dl for the following: 01/12/24 at 10:29 PM the blood glucose reading was 305 mg/dl no insulin administered. 01/13/24 at 08:41 PM the blood glucose reading was 253 mg/dl no insulin administered. 01/18/24 at 08:48 PM the blood glucose reading was 234 mg/dl no insulin administered. 01/19/24 at 09:03 PM the blood glucose reading was 259 mg/dl no insulin administered. Review of the Medication Administration Record (MAR) for Resident #18 dated February 2024 revealed Novolog sliding scale insulin was administered as needed before meals. Novolog sliding scale insulin was not administered at bedtime as needed for blood glucose greater than 200 mg/dl for the following: 02/03/24 at 10:42 PM the blood glucose reading was 248 mg/dl no insulin administered. 02/04/24 at 10:11 PM the blood glucose reading was 235 mg/dl no insulin administered. 02/06/24 at 10:11 PM the blood glucose reading was 215 mg/dl no insulin administered. 02/07/24 at 09:18 PM the blood glucose reading was 348 mg/dl no insulin administered. 02/08/24 at 08:34 PM the blood glucose reading was 274 mg/dl no insulin administered. 02/11/24 at 09:29 PM the blood glucose reading was 203 mg/dl no insulin administered. 02/12/24 at 09:20 PM the blood glucose reading was 204 mg/dl no insulin administered. 02/13/24 at 10:48 PM the blood glucose reading was 341 mg/dl no insulin administered. 02/15/24 at 08:44 PM the blood glucose reading was 207 mg/dl no insulin administered. 02/18/24 at 08:56 PM the blood glucose reading was 253 mg/dl no insulin administered. 02/19/24 at 10:18 PM the blood glucose reading was 204 mg/dl no insulin administered. 02/20/24 at 10:41 PM the blood glucose reading was 204 mg/dl no insulin administered. 02/25/24 at 10:51 PM the blood glucose reading was 225 mg/dl no insulin administered. 02/26/24 at 09:55 PM the blood glucose reading was 284 mg/dl no insulin administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for Resident #18 dated March 2024 revealed Novolog sliding scale insulin was administered as needed before meals. Novolog sliding scale insulin was not administered at bedtime as needed for blood glucose greater than 200 mg/dl for the following: 03/03/24 at 10:26 PM the blood glucose reading was 283 mg/dl no insulin administered. 03/04/24 at 10:32 PM the blood glucose reading was 220 mg/dl no insulin administered. During a phone interview on 03/06/24 at 02:53 PM Medication Aide #1 stated she worked night shift from 7:00 PM through 7:00 AM and routinely provided care to Resident #18. She stated she checked Resident #18's blood sugars two times during her shift, which were at bedtime and in the morning. She stated Resident #18 did not have orders for sliding scale coverage at bedtime and she only received insulin coverage before meals. She indicated Resident #18 was only given sliding scale insulin to cover her blood sugars when she checked her in the mornings. She stated she was not aware that sliding scale insulin was ordered at bedtime and indicated there was no space on the electronic medical record to document that insulin was to be administered at bedtime. She indicated she was not clear on the order if insulin was to be administered at bedtime. She stated as a Medication Aide she would not administer the insulin but would report it to the charge nurse anytime sliding scale insulin was ordered and the nurse would administer it. She reported that Resident #18 was not symptomatic at bedtime when her blood sugar levels were over 200 mg/dl. During a phone interview on 03/07/24 at 12:00 PM Medication Aide #2 stated she worked night shift from 7:00 PM through 7:00 AM and routinely provided care to Resident #18. She stated she checked blood sugars two times during her shift for Resident #18 which were at bedtime and in the morning. She stated Resident #18 did not have orders for sliding scale coverage at bedtime. She stated she would have reported blood sugar readings to the nurse in charge if insulin was scheduled and the nurse would administer the insulin, but no insulin was ordered at bedtime. She indicated she was not clear on the order if Resident #18 was supposed to be given insulin at bedtime. Attempts were made to contact Nurse #1 during the investigation. Nurse #1 was an agency nurse and was on duty during the dates and times the sliding scale insulin was not administered to Resident #18. There was no response. Attempts were made to contact Nurse #2 during the investigation. Nurse #2 was on duty during the dates and times the sliding scale insulin was not administered to Resident #18. Nurse #2 was no longer employed by the facility. There was no response. Attempts were made to contact agency Medication Aides #3, #4, and #5 during the investigation. The Medication Aides were on duty during the dates and times the sliding scale insulin was not administered to Resident #18. There was no response. During an interview on 03/07/24 at 10:18 AM the Physician indicated she was not aware Resident #18 was not getting sliding scale coverage at bedtime. She reported the Nurse Practitioner wrote the order for sliding scale insulin at bedtime. She stated she didn't typically like to prescribe nighttime insulin to residents due to the risk of hypoglycemia. She stated there would not be any significant outcome for Resident #18 not receiving insulin at bedtime and it was probably best that she didn't get the insulin at bedtime. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/07/24 at 11:12 AM the Nurse Practitioner stated she wrote the order for sliding scale insulin in January 2024 and had planned to discontinue the bedtime sliding scale insulin order after a few weeks which would be in February 2024, but she overlooked discontinuing the order. She stated it was fine that Resident #18 wasn't getting sliding scale insulin coverage for the bedtime blood sugar checks even though some of the blood sugar readings were greater than 200 mg/dl because of the risk of hypoglycemia. She stated she planned to change the order today and order blood sugar checks with sliding scale insulin three times a day before meals. During an interview on 03/07/24 at 11: 15 AM the Registered Nurse Supervisor stated that Novolog sliding scale was ordered before meals on 01/11/24, then on 01/12/24 an order was entered for blood sugar checks before meals and at bedtime and to see sliding scale instructions for coverage. She indicated what should have occurred when the order for blood sugars before meals and at bedtime was added the entire order for Novolog sliding scale before meals should have been discontinued and Novolog sliding scale four times a day before meals and at bedtime should have been entered and that was not how it was entered. She indicated this was likely the cause of the bedtime sliding scale insulin order not being followed. During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated medications were reviewed daily in the morning meetings. She indicated she was not aware of the insulin order not being followed for Resident #18. She stated her expectation was for staff to follow the physicians orders and indicated the sliding scale insulin was an active order and should have been followed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40044 Based on observations, record review, and staff interviews the facility failed to record an opened date on two insulin pens and on two opened bottles of eye drops that had shortened expiration dates. This was observed on 1 of 3 medication carts (300 hall medication cart) reviewed for medication storage. Findings included. Review of the manufacturer's instructions for Lantus insulin pens revealed to discard 28 days after opening. Review of the manufacturer's instructions for Brimonidine eye drops revealed to discard 4 weeks after opening. Review of the manufacturer's instructions for Latanoprost eye drops revealed to discard 6 weeks after opening. An observation of the 300-hall medication cart on 03/04/24 at 11:30 AM along with Nurse #3 revealed two Lantus insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens. A bottle of Brimonidine eye drops and a bottle of Latanoprost eye drops were opened with no opened dates labeled on the bottles. During an interview on 03/04/24 at 11:35 AM Nurse #3 stated she was not aware the insulin pens were not dated and indicated she did administer one of the two insulin pens to the resident it was prescribed for earlier today. She stated she was new to the facility and still getting used to procedures. She acknowledged the Lantus insulin pen was not dated and stated she failed to check for an opened date prior to administering the insulin. She indicated she had not administered either of the eye drops and had not checked the bottles for opened dates. During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated insulin pens and eye drops should be labeled with opened dates when they were opened. She stated the nurse should have checked the date prior to administering the insulin. She stated education would be provided.

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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** 35173 Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint survey of [DATE] and the recertification and complaint survey of [DATE]. This was for one deficiency that was originally cited in [DATE] in the area of significant medication errors and for two deficiencies originally cited in [DATE] for medication storage and unnecessary medications. These deficiencies were subsequently recited on the current recertification survey of [DATE]. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F757: Based on observations, record review, staff, and Physician interviews the facility failed to clarify a medication order prescribed for hypotension (low blood pressure) to include hold parameters if the systolic blood pressure was greater than 120 mm/hg (millimeters of mercury). This resulted in a resident (Resident #61) receiving 59 additional doses of the medication. There was no significant outcome from receiving the medication. This occurred for 1 of 3 residents reviewed for medication administration. During the recertification and complaint survey of [DATE] the facility administered a medication to a resident that was not medically justified. An interview was conducted with the Administrator on [DATE] at 3:30 PM. The Administrator stated she believed the QA process needed to be more focused on clarifying orders and reviewing all medications daily for accuracy and following the parameters. F760: Based on observation, record review, staff, Nurse Practitioner, and Physician interviews the facility failed to follow the physicians order and provide sliding scale insulin at bedtime to a resident (Resident #18) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in the resident not receiving a total of 74 units of insulin from [DATE] through [DATE]. There was no significant outcome. This occurred for 1 of 3 residents reviewed for medication administration. During the recertification and complain survey of [DATE], the facility failed to administer intravenous (IV) medication as ordered by the physician. An interview was conducted with the Administrator on [DATE] at 3:30 PM. The Administrator stated she believed the QA process needed to be more focused on clarifying orders and reviewing all medications daily for accuracy and following the parameters. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F761: Based on observations, record review, and staff interviews the facility failed to record an opened date on two insulin pens and on two opened bottles of eye drops that had shortened expiration dates. This was observed on 1 of 3 medication carts (300 hall medication cart) reviewed for medication storage. During a recertification and complaint survey of [DATE] the facility failed to: accurately label and record an opened date on a bottle of tuberculin solution and a bottle of Influenza vaccine; accurately record an opened date on a bottle of eye drops and insulin pens; dispose of expired bottles of nitroglycerin, insulin pens, and bottle of nasal spray; lock and secure a medication cart in an unattended resident care area; and to securely store medication on a medication cart. An interview was conducted with the Administrator on [DATE] at 3:30 PM. The Administrator revealed the facility including the pharmacist and the Director Nursing believed that the problems with medication storage were related to the inconsistency of the staff on the 300 and 500 halls. The Administrator stated two new nurses were hired to be consistent floor nurses for the two halls.