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	495200	A. BUILDING _____ B. WING _____	R 05/12/2023

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid first Revisit survey was conducted 5/10/23 through 5/12/23 as the result of a standard survey conducted 3/12/23 through 3/20/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) Complaints were investigated during the survey: VA00058396 Compliant with Regulations VA00058410 Noncompliant with Deficient Practice cited The census in this 65 certified bed facility was 53 at the time of the survey. The survey sample consisted of 18 current resident reviews and three (3) closed resident reviews.	{F 000}	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in following Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	05/31/2023
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record reviews the facility staff failed to administer provider ordered medications according to professional standards of practice for 1 of 21 sampled residents, Resident #113.	{F 658}	**F658** Resident #113 discharged 2/3/2023 and did not return to the facility. The facility was unable to correct action. All residents receiving medications have the potential to be affected by the alleged deficient practice. Therefore, all authorized nursing access to omnicell was verified on or before 5/24/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 5/24/23

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.

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{F 658}	Continued From page 1 The findings: Facility staff failed to ensure Resident #113 received an ordered antibiotic upon readmission from the hospital. Resident #113's admission record listed diagnoses which included but were not limited to, fracture of left tibia, coagulation defect, and presence of right artificial knee joint. The minimum data set with an assessment reference date of 11/29/22 coded the resident a 13 out of 15 for the brief interview for mental status (BIMS) score. Section G (Functional Status) coded Resident #113 required two plus persons physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. Resident #113's clinical record contained a progress note documented on 01/08/23 at 1:00 p.m. which read the resident had returned from a hospital emergency department visit with diagnoses of sepsis, vomiting and acute UTI. There was a provider's order for Cephalexin Oral Capsule 500mg, give 1 capsule via PEG-Tube every 6 hours for UTI (urinary tract infection) for 7 days to start on 01/09/2023 at midnight (approximately 11 hours after the resident was readmitted to the nursing home). Resident #113's January 2023 medication administration record (MAR) was reviewed and revealed a licensed practical nurse (LPN #3) documented "NN" for two antibiotic doses on 01/09/23; one dose due at midnight, the second dose due at 6:00 a.m. According to the MAR's chart codes, NN meant "No/See Nurses notes". LPN #3 had documented an eMAR progress note	{F 658}	05/31/2023 NPE or designee will re-educate all current licensed nursing staff on the procedure with how to use the omnicell for medications needed and required documentation. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire. An audit of the omnicell access will be completed weekly X4 then monthly X2 or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review	

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{F 658}	Continued From page 2 on 01/09/23 at 00:34 a.m. and again on 01/09/23 at 6:35 a.m. that the medication, Cephalexin (an antibiotic) at not been received. The resource nurse consultant provided a list of medications kept in the facility's medication distribution system (Omnicell). Cephalexin 500 mg capsules were listed on the Omni Inventory as being available. LPN #3 was interviewed via phone on 05/11/23 at 10:26 a.m. The nurse did not recall Resident #113's readmission medication order specifically but reported when a medication was supposed to start at midnight and did not arrive from the pharmacy, the nurse should get the medication out of the Omnicell. The nurse stated she did not have access to the Omnicell until approximately one month ago. LPN #3 stated until recently, there was only one night-shift nurse who had access to the Omnicell, and that one nurse might not have been working the night Resident #113's needed the antibiotic. The resource nurse and director of nursing (DON) were informed of these findings on 05/11/23 at approximately 1:45 p.m. with the administrator joining the conversation at 2:00 p.m. The DON reported being unaware there were nurses who could not access Omnicell until recently. Surveyor requested a policy related to medication administration and/or medication availability. On 5/12/23 at 2:15 p.m., prior to the exit conference the resource nurse was unable to provide a policy except how to input medications in the computer software program. The resource nurse acknowledged communicating with a corporate employee regarding the requested policy(ies) and there was no policy found	{F 658}	This page intentionally left blank.	

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{F 658}	Continued From page 3 regarding medication availability. The resource nurse said the expectation was for nurses to have access to Omnicell so medications could be administered while awaiting the pharmacy delivery.	{F 658}		05/31/2023
{F 693} SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that residents who are fed by enteral means receives appropriate treatment and services to prevent complications for 1 of 21 residents in the survey sample, Resident #114.	{F 693}	**F693** Resident #114 the physician/NP order for gastric residual volume check as corrected at the time of the survey. All residents who receive enteral feed have the potential to be affected by the alleged deficient practice. An audit was completed and no other residents require enteral feeding at this time. NPE or designee will re-educate all current licensed nursing staff on the procedure of obtaining the orders for enteral feeding and to ensure that there are not duplicate orders. The NPE/designee will also	

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{F 693}	Continued From page 4 The findings included: For Resident #114, the facility staff failed to clarify the physician's orders for gastric residual volume checks. Resident #114's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia Affecting Right Dominant Side, Bell's Palsy, Epilepsy, Dysphagia, and Aphasia. The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 3/30/23 coded the resident as being severely impaired in cognitive skills for daily decision making. Resident #114 was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc per day or more of average fluid intake during the last seven days. Resident #114's current comprehensive person-centered care plan included an intervention dated 4/07/23 to check for residual prior to medication administration and feeding every day and night shift and hold as indicated. Resident #114's clinical record included two current conflicting physician's orders for gastric residual volume checks. The first order dated 5/07/21 stated check for residual prior to medication administration and feeding every day and night shift prior to feeding. If 100 ml or over, hold feeding for one hour and recheck, if residual remain 100 ml or over upon recheck, hold feeding and notify the physician. The second order dated 4/24/23 stated check for gastric residual volume prior to feeding every 12 hours, if 500 ml or over,	{F 693}	provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire. An audit of the enteral feedings will be completed during the clinical morning meeting to ensure there are no duplicated orders weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	05/31/2023

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{F 693}	Continued From page 5 hold feeding for one hour and recheck, if the residual is 250 ml or over upon recheck, hold feeding and notify physician. According to Resident #114's May 2023 Medication Administration Record (MAR), both orders for gastric residual volume checks were being completed and documented. The 4/24/23 order was being completed daily at 9:00 am and 9:00 pm and the 5/07/21 order was being completed daily during the day and night shift. All documented gastric volume residuals were documented as zero. On 5/11/23 at 10:56 am, surveyor spoke with the director of nursing (DON) and notified them of the conflicting orders for Resident #114's gastric residual volume checks. Surveyor requested and received the facility policy entitled "Enteral Feeding: Administration by Pump" which read in part: 13. Check gastric residual volume (GRV). Inspect the visual characteristics of the aspirate and return aspirated contents to the stomach. 13.1 Hold feeding if GRV is greater than 500 ml. Re-check in one hour. 13.1.1 If GRV is greater than 250 ml after one hour, hold feeding and notify physician/APP. On 5/11/23 at approximately 2:45 pm, surveyor met with the administrator, DON, and Resource Nurse and discussed Resident #114's conflicting GRV orders. The DON stated the orders have been corrected. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/12/23.	{F 693}	This page intentionally left blank.	

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure one out of 21 residents were free from medication errors, Resident #104. The findings included: For Resident #104 the facility staff administered the medications enalapril and metoprolol outside the physician ordered parameters on separate occasions. Enalapril and metoprolol are both medications used to treat high blood pressure. Resident #104's face sheet listed diagnoses which included but not limited to essential (primary) hypertension (high blood pressure). The most recent minimum data set with an assessment reference date of 02/07/23 assigned the resident a brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #104's comprehensive care plan was reviewed and contained a care plan for "Resident exhibits or is at risk for cardiovascular symptoms or complications related to HTN (hypertension), edema, increasing risk of CVA (cerebrovascular accident [stroke])/kidney disease." Interventions for this care plan included "Administer meds as ordered and assess for effectiveness and side	F 760	**F760** Resident #104 physician/NP was notified. Physician/NP reviewed the medications and vital signs and discontinued the medications. All residents who receive hypertensive medications with parameters have the potential to be affected by the alleged deficient practice. An audit of residents with prescriptions for hypertensive with parameters will be completed for the previous 2 weeks with corrective action if needed. This audit to be completed on or before 5/31/2023	05/31/2023

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F 760	Continued From page 7 effects and report abnormalities to physician." Resident #104's clinical record was reviewed and contained a physician's order summary for the month of May 2023 which read in part, "Enalapril Maleate Tablet 10 mg. Give 1 tablet by mouth one time a day for Hight Blood Pressure hold if SBP (systolic blood pressure) is less than 110" and "Metoprolol Tartrate Tablet 100 mg. Give 1 tablet by mouth one time a day for High Blood Pressure. Hold if SBP is lower than 100." Resident #104's electronic medication administration record (eMAR) for the month of May 2023 was reviewed and contained entries as above. The entry for enalapril was initialed as given on 05//05/23 with a SBP of 102, 05/06/23 with a SBP of 100, and on 05/09/23 with a SBP of 82. The entry for metoprolol was initialed as given on 05/04/23 with a SBP 87. Resident #104's nurses' progress notes were reviewed, and surveyor was unable to find any notes related to the above dates. Surveyor requested and was provided with a facility policy entitled "Medication Administration: Oral", which read in part "2.4 Verify medication order on Medication Administration Record (MAR) with mediation label for: 2.4.4 Special considerations" Surveyor spoke with the director of nursing (DON) and resource nurse on 05/11/23 at 1:50 pm regarding Resident #104. Resource nurse stated that a QAPI (quality assurance performance improvement) plan was implemented on 05/04/23 due to identified issues with medication administration, documentation,	F 760	05/31/2023 NPE or designee will re-educate all current licensed nursing staff on the administering hypertensive with parameters. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire. An audit for hypertensive parameter medications will be completed daily during the clinical morning meeting weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	

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F 760	Continued From page 8 etc. Resource nurse stated this plan was ongoing. The concern of administering Resident #104's blood pressure medications outside of physician ordered parameters was discussed with the administrator, DON, and resource nurse during a meeting on 05/11/23 at 5:15 pm. No further information was provided prior to exit.	F 760	F842 1.) #103 documentation was completed upon discovery. All residents with treatment orders have the potential to be affected by the alleged deficient practice. An audit was completed of all current wound care to ensure documentation was completed for each treatment with corrective action if needed. This audit to be completed on or before 5/31/2023 NPE or designee will re-educate all current licensed nursing staff on the wound treatment documentation process. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire.	05/31/2023
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		

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F 842	Continued From page 9 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842	An audit for wound treatment documentation will be completed during the clinical morning meeting weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review. 2.) #108 urine sample documentation was corrected on or before 5/31/2023 All residents with urine sample orders have the potential to be affected by the alleged deficient practice. An audit was completed on documentation of catheterizations ordered for the past 2 weeks with corrective action if needed. This audit to be completed on or before 5/31/2023	05/31/2023

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F 842	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility document review, the facility staff failed to maintain complete and/or accurate clinical record/documentation for four of 21 sampled residents, Resident #103, Resident #108, Resident #117, and Resident #106. The findings were: 1. The facility staff failed to document Resident #103's dressing changes accurately. Resident #103's minimum data set with an assessment reference date of 02/01/2023 coded the resident as a 14 out of 15 in the brief interview for mental status (BIMS) summary score in Section C - cognitive patterns. Resident #103 required assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene as coded in Section G (Functional Status). Resident #103's clinical record contained a provider order dated 05/04/23 for wound care/surgical incision right below knee amputation (BKA): cleanse with inhouse wound cleanser (IHWC), pat dry, cover small open area with xeroform, then with non-stick telfa and ABD pad. Secure with Kling or Kerlix every day shift every 2 days for wound care. A review of the resident's treatment administration record (TAR) for the month of May 2023 identified the wound care order was documented as completed on Thursday (05/04/23), Saturday (05/06/23), Monday (05/08/23), and Wednesday (05/10/23). On Thursday 05/11/23, the facility's assistant director of nursing (ADON) prepared to change	F 842	NPE or designee will re-educate all current licensed nursing staff on the required documentations of catheterizations orders including but not limited to resident refusals. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire. An audit for refusal documentation for catheterization orders will be completed during the clinical morning meeting weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review. 3.) #117 NP was notified and confirmed they did not wish to continue the multivitamin	05/31/2023

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F 842	Continued From page 11 the resident's dressing with this surveyor observing the treatment. The ADON said the dressing was due to be changed since it was last changed on Tuesday (05/09/23) and it was due every other day. The resident acknowledged his dressing had been changed by the director of nursing (DON) on Tuesday because the DON wanted to take pictures as part of a weekly assessment. Resident #103's wound dressing had the date 05/09/23 (Tuesday) written on it prior to the ADON changing the dressing on 05/11/23. The DON was asked about Resident #103's dressing change and she acknowledged she changed his dressing on Tuesday, 05/09/23 as part of a weekly assessment to include pictures. The DON did not have an explanation why that dressing change was not documented in the clinical record, either in the TAR or in the progress notes, and voiced she thought she did document the treatment. The licensed practical nurse (LPN #4) who documented the dressing change was completed on Wednesday 05/10/23, was interviewed on the phone with the administrator present. The LPN was aware the administrator was present and stated he had changed the dressing on Monday and knew it was due every other day. When the nurse went into the room on Wednesday, the resident said his dressing had been changed the day before and was not due therefore, the LPN did not change the dressing. The LPN#4 stated he had "charted in error" that he changed the dressing on Wednesday and should have made a progress note and should have gone into the computer to "strike out" the documented treatment for Wednesday 05/10/23.	F 842	with folic acid and duoneb nebulizer treatments, pulmicort nebulizer treatments, ferrous sulfate and midodrine. NP stated they instructed the nurse to stop those orders until they saw the resident. All residents admitting with medications have the potential to be affected by the alleged deficient practice. An audit was completed on the past 7 days of admissions of medications documentations for physician/NP notification with corrective action if needed. This audit to be completed on or before 5/31/2023. NPE or designee will re-educate all current licensed nursing staff on the required documentation of physician/NP notification of medications with any medications changes. The NPE/designee will also	05/31/2023

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F 842	Continued From page 12 On 05/12/23 at approximately 10:50 a.m., Resident #103's May 2023 TAR was reviewed. LPN#4 had updated the documentation for that dressing change as "NN" meaning "No/See Nurses Notes" with a progress note that read the resident had refused the dressing change on Wednesday. However, the dressing change the DON completed on Tuesday (05/09/23) was not documented on the TAR. There was a late entry progress note made on 05/11/23 at 3:52 p.m. that the DON had changed the dressing on 05/09/23 as part of a "Swift assessment." The dressing change the ADON completed with the surveyor observing on Thursday (05/11/23) had not been documented in the TAR or progress notes. On 05/11/23 at 11:05 a.m., the administrator and regional consultant were notified of the continued documentation concerns related to Resident #103's dressing changes. LPN #4 was interviewed on 05/12/23 at 11:15 a.m. in the conference room with the administrator and resource consultant nurse present. The LPN acknowledged Resident #103 did not use the word "refused" the dressing change on 05/10/23 but when the nurse said he was going to change the dressing, the resident reported the dressing had been changed yesterday. The LPN said, "That's what I'd call refusing." The resource consultant nurse provided a policy titled "NSG113 Nursing Documentation" which read in part, "PRACTICE STANDARDS 1. Documentation of nursing care is recorded in the medical record and is reflective of the care provided by nursing staff. Nurses will not: 1.1	F 842	provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire. An audit of admissions medication documentation for physician/NP notification with any medication changes will be completed during the clinical morning meeting weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review 4.)#104 documentation was corrected at the time of survey.	05/31/2023

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F 842	Continued From page 13 Document services that were not performed; 1.2 Document services before they are performed;". No further information was provided prior to the exit conference. 2. For Resident #108, the facility staff failed to document the resident's refusal to allow staff to obtain a urine sample on two separate occasions. Resident #108's diagnosis list indicated diagnoses, which included, but not limited to Nontraumatic Subarachnoid Hemorrhage, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Retention of Urine, and Bipolar Disorder. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/23/23 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 indicating the resident was severely cognitively impaired. Resident #108's clinical record included a provider's order dated 5/05/23 for a urinalysis with reflex culture for dysuria. Surveyor was unable to locate results of the urinalysis in the resident's clinical record. Surveyor requested and received the urinalysis results from the assistant director of nursing (ADON). According to Resident #108's urinalysis results, the sample was collected on 5/07/23 at 7:33 am. On 5/11/23 at 9:18 am, surveyor spoke with the ADON and asked why the urine sample was not collected until 5/07/23 and the ADON stated Resident #108 refused the in and out catheterizations to collect the urine on 5/05/23 and 5/06/23. Surveyor then inquired why the	F 842	All residents with medication administration have the potential to be affected by the alleged deficient practice. An audit of residents' medication administration will be completed for the previous 2 weeks with corrective action if needed. NPE or designee will re-education the required documentation to be completed for medication administration. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire.	05/31/2023

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F 842	Continued From page 14 refusals were not documented in the resident's clinical record and the ADON stated "I don't know because I told them to." Surveyor requested and received the facility policy entitled "Nursing Documentation" which read in part " ...2. Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes, and responses to nursing care ..." On 5/11/23 at approximately 2:45 pm, surveyor met with the administrator, director of nursing, and resource nurse and discussed the concern of staff failing to document the resident's refusals to allow staff to obtain a urine collection on 5/05/23 and 5/06/23. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/12/23. 3. For Resident #117, the facility staff failed to document the provider's order not to initiate orders from the hospital discharge summary for the following medications: multivitamin with folic acid, Duoneb nebulizer treatments, Pulmicort nebulizer treatments, ferrous sulfate, and midodrine. Resident #117's diagnosis list indicated diagnoses, which included, but not limited to Malignant Neoplasm of Colon, Protein-Calorie Malnutrition, Atrial Fibrillation, and Barrett's Esophagus. According to the 5/04/23 "Nursing Documentation -V11" assessment, Resident #117 was coded as	F 842	An audit of medication administration documentation will be will be completed during the clinical morning meeting weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review	05/31/2023

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F 842	Continued From page 15 being alert and oriented to person, place, and time with modified independence in decision making skills for daily routines. Resident #117's clinical record included a hospital discharge summary dated 5/04/23 which included discharge orders for multivitamin with folic acid, Duoneb nebulizer treatments, Pulmicort nebulizer treatments, ferrous sulfate, and midodrine. Surveyor reviewed the resident's admission orders and was unable to locate the medication orders. On 5/11/23 at 10:24 am, surveyor spoke with nurse practitioner (NP) who stated the facility nurse did call them to review Resident #117's discharge summary and they did not wish to continue the orders for multivitamin with folic acid, Duoneb nebulizer treatments, Pulmicort nebulizer treatments, ferrous sulfate, and midodrine. NP stated they instructed the nurse to stop those orders until they saw the resident. On 5/11/23 at 12:20 pm, surveyor spoke with licensed practical nurse (LPN) #1, the facility admitting nurse, and inquired about the provider orders for multivitamin with folic acid, Duoneb nebulizer treatments, Pulmicort nebulizer treatments, ferrous sulfate, and midodrine. LPN #1 stated they spoke with the NP, and they did not want to continue those orders and they should have put a note in the chart. Surveyor requested and received the facility policy entitled "Nursing Documentation" which read in part " ...2. Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes,	F 842	This page intentionally left blank.	

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F 842	Continued From page 16 and responses to nursing care ..." On 5/11/23 at approximately 2:45 pm, surveyor met with the administrator, director of nursing, and resource nurse and discussed the concern of staff failing to document the provider's decision not to initiate orders from the hospital discharge summary. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/12/23. 4. For Resident #106 the facility staff failed to document the administration of medications. Resident #106's face sheet listed diagnoses which included but not limited to acute pancreatitis, diabetes mellitus type 2, hypothyroidism, hyperlipidemia, glaucoma, and hypocalcemia. Resident #104's most recent minimum data set with an assessment reference date of 04/19/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Surveyor reviewed Resident #104's comprehensive care plan, which contained care plans for "Resident exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of HTN (hypertension)", "The resident has a diagnosis of diabetes: insulin dependent", "Hypothyroid disease", and "Resident has vision impairment related to Glaucoma." Interventions for these care plans	F 842	This page intentionally left blank.	

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F 842	Continued From page 17 included "administer medications as ordered." Resident #104's clinical record was reviewed and contained a physician's order summary for the month of May 2023, which read in part "Atorvastatin Calcium Oral Tablet 10 mg (Atorvastatin Calcium). Give 10 mg by mouth at bedtime for HLD (hyperlipidemia)", "Brimonidine Tartrate-Timolol Ophthalmic Solution 0.2-0.5% (Brimonidine Tartrate-Timolol Maleate). Instill 1 drop in both eyes every morning and at bedtime for glaucoma", "Humalog Subcutaneous Solution (Insulin Lispro). Inject 6 unit subcutaneously before meals for DM (diabetes mellitus) type 2. Hold for glucose under 150", "Lantus Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 17 unit subcutaneously every morning and at bedtime for diabetes", "Latanoprost Solution 0.005%. Instill 1 drop in both eyes at bedtime for glaucoma", "Levothyroxine Sodium Oral Tablet 75 mcg (levothyroxine Sodium). Give 1 tablet by mouth in the morning for hypothyroid", "Lisinopril Oral Tablet 5 mg (lisinopril). Give 1 tablet by mouth at bedtime for HTN (hypertension)", "Midodrine HCl Tablet 10 mg. Give 1 tablet by mouth three times a day for hypotension", and "Sevelamer Carbonate Tablet 800 mg. Give 1 tablet by mouth before meals for hypocalcemia." Resident #104's electronic medication administration record (eMAR) was reviewed and contained entries as above. The entries for atorvastatin, brimonidine, Lantus, latanoprost, lisinopril, and midodrine were not initialed on 05/04/23 at 9:00 pm. The entries for brimonidine, Humalog, levothyroxine, and sevelamer were not initialed on 05/05/23 at 6:30 am.	F 842	This page intentionally left blank.	

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F 842	Continued From page 18 Surveyor reviewed Resident #106's nurses' progress notes and could not find any notes that indicated the medications were held/not administered. Surveyor spoke with the director of nursing (DON) and resource nurse on 05/11/23 at 1:50 pm regarding Resident #106. Resource nurse stated that a QAPI (quality assurance performance improvement) plan was implemented on 05/04/23 due to identified issues with medication administration, documentation, etc. Resource nurse stated this plan was ongoing. Surveyor spoke with the DON on 05/11/23 at 4:45 pm, and DON stated they had talked with the nurse working the 7p-7a shift on 05/04-05/05/23, and that nurse stated they do not know why the medications were not documented as administered, and they do not recall not administering the medications. Surveyor requested and was provided with a facility policy entitled "Medication Administration: Oral", which read in part "7. Document: 7.1 Administration of medication; 7.4 If drug is withheld, record reason." The concern of not documenting medications administered was discussed with the administrator, DON, and resource nurse on 05/11/23 at 5:15 pm. No further information provided prior to exit.	F 842	This page intentionally left blank.	

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid first Revisit survey was conducted 5/10/23 through 5/12/23 as the result of a standard survey conducted 3/12/23 through 3/20/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) Complaints were investigated during the survey: VA00058396 Compliant with Regulations VA00058410 Noncompliant with Deficient Practice cited The census in this 65 certified bed facility was 53 at the time of the survey. The survey sample consisted of 18 current resident reviews and three (3) closed resident reviews.	{F 000}		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure one out of 21 residents were free from medication errors, Resident #104. The findings included:	F 760	F760 Resident #104 physician/NP was notified. Physician/NP reviewed the medications and vital signs and discontinued the medications. All residents who receive hypertensive medications with parameters have the potential to be affected by the alleged deficient practice. An audit of residents with prescriptions for hypertensive with parameters will be completed for the previous 2 weeks with corrective action if needed. This audit to be completed on or before 5/31/2023 NPE or designee will re-educate all current licensed nursing staff on the administering hypertensive with parameters. The NPE/designee will also	05/31/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 5/24/23

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.

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F 760	Continued From page 1 For Resident #104 the facility staff administered the medications enalapril and metoprolol outside the physician ordered parameters on separate occasions. Enalapril and metoprolol are both medications used to treat high blood pressure. Resident #104's face sheet listed diagnoses which included but not limited to essential (primary) hypertension (high blood pressure). The most recent minimum data set with an assessment reference date of 02/07/23 assigned the resident a brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #104's comprehensive care plan was reviewed and contained a care plan for "Resident exhibits or is at risk for cardiovascular symptoms or complications related to HTN (hypertension), edema, increasing risk of CVA (cerebrovascular accident [stroke])/kidney disease." Interventions for this care plan included "Administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician." Resident #104's clinical record was reviewed and contained a physician's order summary for the month of May 2023 which read in part, "Enalapril Maleate Tablet 10 mg. Give 1 tablet by mouth one time a day for Hight Blood Pressure hold if SBP (systolic blood pressure) is less than 110" and "Metoprolol Tartrate Tablet 100 mg. Give 1 tablet by mouth one time a day for High Blood Pressure. Hold if SBP is lower than 100." Resident #104's electronic medication administration record (eMAR) for the month of	F 760	provide the education to all additional and newly hired licensed nursing staff prior to their start of their first shift. This education to be completed on or before 5/31/2023 or upon hire. An audit for hypertensive parameter medications will be completed daily during the clinical morning meeting weekly X4 then monthly X2 or until 100% complaint, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	05/31/2023

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F 760	Continued From page 2 May 2023 was reviewed and contained entries as above. The entry for enalaprii was initialed as given on 05//05/23 with a SBP of 102, 05/06/23 with a SBP of 100, and on 05/09/23 with a SBP of 82. The entry for metoprolol was initialed as given on 05/04/23 with a SBP 87. Resident #104's nurses' progress notes were reviewed, and surveyor was unable to find any notes related to the above dates. Surveyor requested and was provided with a facility policy entitled "Medication Administration: Oral", which read in part "2.4 Verify medication order on Medication Administration Record (MAR) with mediation label for: 2.4.4 Special considerations" Surveyor spoke with the director of nursing (DON) and resource nurse on 05/11/23 at 1:50 pm regarding Resident #104. Resource nurse stated that a QAPI (quality assurance performance improvement) plan was implemented on 05/04/23 due to identified issues with medication administration, documentation, etc. Resource nurse stated this plan was ongoing. The concern of administering Resident #104's blood pressure medications outside of physician ordered parameters was discussed with the administrator, DON, and resource nurse during a meeting on 05/11/23 at 5:15 pm. No further information was provided prior to exit.	F 760	05/31/2023 The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in following Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	