STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. BUILDING ______ B. WING ______	R-C 07/20/2023

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CARRINGTON PLACE OF TAPPAHANNOCK	1150 MARSH STREET TAPPAHANNOCK, VA 22560

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted 05/30/2023 through 06/01/2023, was conducted 07/18/2023 through 07/20/2023. The facility was not in compliance with 42 CFR Part 483 the Federal Long-Term Care regulations. One complaint was investigated during the survey. VA00059139 substantiated with deficiency. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 20 resident reviews.	{F 000}		
{F 554} SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to assess for appropriateness of self-administration of medications for 1 Resident (Resident #17) in a survey sample of 20 Residents. The findings included: For Resident #17, the facility allowed the Resident to have a 4 oz container of pain-relieving foot cream in her room, at the bedside, without first assessing the Resident's ability to self-medicate.	{F 554}	1.Resident #17 did not have any negative outcomes while pain cream was in room with self-use. Self-administration assessment was completed on 7/19/2023. The cream was removed from her room on 7/19/2023. The cream is kept in a secure location by the nurses on the treatment cart and the resident may put on by self with supervision of the nurse. 2.All resident rooms were assessed for any medications or medicated creams that are not in a secured lock box. Any items found were removed from rooms if the resident was not able to pass a	8/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2023

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 554}

Continued From page 1

On 7/18/23 at approximately 2:00 PM, Resident #17 was noted to have a container of pain-relieving foot cream at the bedside.

On 7/19/23 at approximately 8:30 AM, Resident #17's room was observed and again the container of pain-relieving foot cream was noted on the bedside table.

On the morning of 7/19/23, a clinical record review was conducted of Resident #17's chart. This chart revealed no physician order, no assessment of her ability to safely self-administer medications, nor any mention of the pain reliving foot cream. Resident #17's care plan did indicate Resident #17 was at risk for pain and discomfort. The interventions for this read, "Administer analgesic pain medication as ordered and Evaluate and treat pain". The pain-relieving foot cream was not addressed on the care plan nor the Resident's ability to self-administer medications.

On the afternoon of 7/19/23, the Director of Nursing (DON) accompanied Surveyor C to the room of Resident #17 and observed the pain-relieving foot cream at the bedside. The DON stated that the Resident had been on a leave of absence and staff would not have entered the room. Surveyor C explained that the staff would still have to enter to provide care to the roommate and with it being unsecured, it was very visible.

During the above observation in Resident #17's room with the DON present, Resident #17 returned from leave of absence. The Resident was interviewed and stated her sister had brought her the cream "a while ago" and she puts it on

{F 554}

self-medication administration assessment. If resident is found able to keep at bedside then a secure box was given to resident to keep the medication or medicated creams in.

3.Residents/Responsible party that have a BIMS of 9 or better were educated about not being able to have non-secured medications or medicated creams in the room. Education with residents/responsible party completed on 8/8/2023 by the social worker. Families were sent letter to please not bring in Prescription medications, OTC, or any type of creams without speaking to the nurses as we have to have orders and the resident would have to have a assessment prior to make sure can have such items independently in the room and these items have to be secure. This letter was sent on 8/7/2023 by the Administrator. All staff was educated on meds and creams not being able to be in rooms not secured and if see to report to the Nurse manager immediately, education completed on 8/8/2023 by DON.

4.Audits will be conducted weekly of all resident rooms to make sure that residents allowed to have meds in room that they are compliant with keeping them locked and secure. That residents that are not allowed to have medications or creams in room that there are no items in room that should not be, and those items are removed, and families/resident notified of the removal. If resident is new

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{F 554}	Continued From page 2 her feet. The DON removed the item. On 7/19/23 at approximately 4:15 PM, the survey team was provided a "Self-Administration of Medications" assessment that had been completed on Resident #17 following the surveyor bringing it to the facility staff's attention. The assessment indicated that the recommendation was: "Resident can assist with administration of cream with supervision of a licensed nurse. Cream to be stored in locked unit by nursing staff". Review of the facility policy titled; "Self-Administration of Medications" was conducted. This policy read, "1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident... 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents...". On 7/19/23, during the end of day meeting, the Administrator and Director of Nursing were made aware of the concern and no further information was provided.	{F 554}	a self-medication assessment will be conducted to see if can keep items secure in room before removing. This audit will be conducted weekly by the Administrator and reported to monthly QAPI for 3 months. 5.DOC 8/31/2023	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		8/31/23

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F 580	Continued From page 3 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to	F 580		

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F 580	Continued From page 4 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to inform the physician of a change in condition or need to alter treatment for 1 Resident (#11) in a survey sample of 20 Residents. The findings included: For Resident #11, the facility staff failed to notify the Physician about a double lumen PICC (Peripherally Inserted Central Catheter) having a clogged port. On 7/18/23 at approximately 12:15 PM an interview was conducted with Resident #11 who stated she was not happy about being in the facility but understood she needed to have IV antibiotics and therapy. A review of the clinical record revealed that Resident #11 was admitted to the facility with orders that included. "NAFCILLIN 2 GRAM/100 ML IN DEXTROSE(ISO-OSMOTIC) INTRAVENOUS PIGGYBACK-: intravenously Every 4 Hours Daily. - infuse 100ml q4h." A review of the clinical record revealed that the Resident received her antibiotics as ordered however the following was entered into the progress notes: "7/18/23 at 4:43 PM -PICC blue port unable to flush red line patent right arm +3 pitted edema	F 580	1.Resident #11 □ MD was notified of PICC being clogged on 7/19/2023 by the DON. No ill-effect on the resident. 2.An audit was completed, no other residents have a PICC line in the facility. 3.The DON or assignee educated all nurses including agency on what to do if a PICC line is clogged. (Notify the MD, hold order if needed if resident does not have a double lumen, Notify the nurse manager on duty, document, carry out MD/NP order if order to call pharmacy for IV team to come and give activase) Education completed on 8/8/2023. 4.Any resident with PICC lines will be on high-risk rounds by the nurse manager to check daily to make sure the PICC lines are patent and report findings daily in the clinical morning meeting if there are issues noted. DON will monitor progress notes for documentation of issues with PICC lines in the clinical morning meeting. Any findings will be reported monthly to QAPI for the next 3 months. 5.DOC 8/31/2023	

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F 580		F 580		

Continued From page 5
dsgs intact anxiety high T 98.1 ABX Role: NUR, Category: Nurses Notes, Significance: Medium."

On 7/19/23 at 1:30 PM an interview was conducted with LPN D who stated that the purple port was clogged but that she was giving the antibiotics through the red port. When asked if that was typically used for lab draws, she indicated that it was however it was the only way to give the antibiotics since the other port was clogged.

On 7/19/23 at 1:45 PM the DON was interviewed and asked if she was aware of Resident #11's clogged port in her PICC line and she stated that she was not aware. Surveyor accompanied the DON to speak with LPN D. The DON asked LPN D if there was a problem with the PICC line for Resident #11. LPN D stated, " The purple lumen is not patent it looks like someone tried to draw blood from it." LPN D tried to flush it and met resistance. She stated, "I was going to let LPN B know but haven't gotten to it yet."

The DON was asked by Surveyor B asked the DON what the danger is with a clogged PICC line, and she stated well it can get pushed through if someone tries to flush the line and pushes too hard and cause a blood clot to enter the bloodstream. The DON was asked what protocol is for a clogged PICC line and she stated, "My next step is I'm going to notify the nurse practitioner that the line is clogged then she can order the Activase and then I will contact pharmacy, so they contact IV team."

On 7/20/23 at 11:00 AM, the DON was asked about an update on Resident's PICC line she stated that the Resident was doing fine, and the

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F 580	Continued From page 6 nurse practitioner had ordered the Activase, and the Pharmacy IV team would be in to unclog the port however they did not have an estimated time of arrival yet. On 7/20/23 the Administrator was made aware of the concerns and no further information was provided.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must	F 585		8/31/23

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F 585	Continued From page 7 include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the	F 585		

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F 585	Continued From page 8 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to make prompt efforts to address grievances for 1 Resident in a survey sample of 20 Residents. The findings included: For Resident # 3 the facility staff failed to ensure that a grievance filed on 6/13/23 were promptly addressed. The grievance was not addressed until 7/18/23. The grievance form dated 6/13/23 read:	F 585	1.Resident #3 grievance was resolved on 7/18/2023. 2.All grievances currently are resolved. Any grievance received in the future will be resolved within 72 hours and reviewed by the administrator that the resolutions area satisfactory. 3.The administrator or designee will educate all staff on the grievance policy and expectations of time of resolution. Education completed by 8/8/2023.	

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F 585	Continued From page 9 "Resident has concerns with [LPN E name redacted], he stated on Saturday 6/3/23 on 7-3 shift resident asked nurse [LPN E name redacted] to change his bandages at 11:30 AM she said yes she would but then did not return to do the dressing changes. Then again on 6/6/23 on the 3-11 shift the resident asked her to change his bandages at a little after 3 pm she said yes but never came back to do it." "Investigation / Findings" "Spoke with the nurse in regard to above concern, Nurse voiced she told the resident that she would check the order and complete treatment. Nursed voiced before she could get back to do the treatment resident was sent out of the facility to the ER." On 7/18/23 a review of the clinical record revealed the following progress note: "7/18/23 at 12:34 PM - SS Note for 07/18/2023 SW went to visit with resident, as he had some concerns about a Grievance he did back in June. SW misunderstood thinking that DON had talked with resident, So I apologized to him for not coming sooner. Then informing resident of the outcome. Resident then wanted to talk with DON, so writer went to get DON & they went back to visit resident in room. [DON name redacted] talked with resident telling him that she had talked to staff & re - educated them on the situation."	F 585	All grievances will be reviewed during in the morning stand up meeting and given to the appropriate person at that time to resolve the issue. All grievances will be documented on a log of when the grievance come in and when resolved. 4.All grievances will be reviewed during the monthly QAPI meeting that the grievances were timely, and the resident/family was happy with the resolution. The grievance log will be used as the audit tool. Review for 3 months. 5.DOC 8/31/2023	
{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,	{F 658}		8/31/23

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{F 658} Continued From page 10
as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, clinical record review the facility staff failed to provide care and services that meet professional standards of quality for 2 Residents (# 3 and #8) in a survey sample of 20 Residents.

The findings included:

For Resident #3 the facility staff failed to provide treatments as ordered by the physician.

On 7/18/23 a review of the clinical record revealed that Resident #3 had the following treatment orders.

A. "Left dorsal foot, cleanse with saline, apply primary dressing silver alginate cover secondary dressing border foam. 3x week and as needed Order Date: 5/24/23 Start Date: 5/24/23 Discontinue Date: 6/06/23."

B. "Left heel cleanse with saline, apply primary dressing silver alginate cover with secondary dressing border foam change 3x week and as needed. Order Date: 5/24/23 Start Date: 5/24/23 Discontinue Date: 6/06/23"

C. "Left leg cleanse with saline, apply primary dressing silver alginate cover with second dressing border foam 3x week and as needed Order Date: 5/24/23 Start Date: 5/24/23.

D. "Clean abdominal incision with normal saline, pat dry, cover with dry dsg daily. Order Date:

{F 658}

1.Resident #3 did not have any ill effects of treatment not being changed. MD was notified on 7/18/2023 of the omissions in the TAR not completed on 6/1, 6/2, 6/3, 6/4, and 6/5. Nurses that did not sign off the TAR was given 1-1 in-services on professional standards.

Resident #8 did not have any ill effects of treatment not being changed. MD was notified on 7/18/2023 of the omissions in the TAR and the treatments not completed on 7/12, 7/14, 7/16, and 7/17. Nurses that did not sign off the TAR and the nurse that did sign TAR and not completed the treatment were given 1-1 in-services on professional standards.

2.All residents TARS were reviewed for the month of June and July for omissions. MD/NP was notified of all findings on 8/3/2023. No ill-effects to any residents of the findings.

3. All nurses including agency educated on signing off the TAR and completing treatments as per the MD order. Reviewed policy of following MD orders. Education completed by DON or designed by 8/8/2023.

4. Missing documentation report will be run daily by the DON to ensure that there are no omissions in the TAR. This will be

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 658}	Continued From page 11 5/25/23 Start Date: 5/25/23 Discontinue Date: 6/06/23 Discontinue Date: 6/06/23" A review of the TAR (Treatment Administration Record) revealed orders "A, B, and C" were not signed off has having been completed on 6/5/23. A review of the TAR revealed order "D" was not signed off as being completed on 6/1/23, 6/2/23, 6/3/23, 6/4/23 and 6/5/23. A review of the clinical record revealed there was no documentation stating the resident refused care. On 7/19/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #8 the facility staff failed to provide treatments as ordered by the physician. On 7/18/23 at approximately 1:00 PM Surveyors B & C observed Resident #8 with bilateral lower leg dressings dated 7/15/23. A review of the clinical record revealed the following treatment orders. "BACITRACIN 500 UNIT/GRAM TOPICAL OINTMENT: Clean bilateral leg wounds with NS. Apply bacitracin 500 units/g to wounds daily and cover with nonstick dressing x 7 days Order Date: 7/11/23 Start Date: 7/11/23 Stop Date: 7/18/23." A review of the TAR (Treatment Administration Record) revealed the nurse had not signed off as	{F 658}	reviewed in the clinical morning meeting and all findings reported to monthly QAPI times 3 months. 5. DOC 8/31/2023	

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{F 658}	Continued From page 12 having done the dressing changes on 7/12, 7/14, 7/17 on the day of survey 7/18/23 the bandages were dated 7/15/23 yet on 7/16/23 it was signed off as being done. A review of the clinical record revealed there were no documentation of refusal of care or refused to have dressing changes. On 7/18/23 at approximately 1:00 PM, Surveyor C went with the DON to show her the dressings still having a date of 7/15/23 and the DON stated that she wasn't aware if the order was for daily dressing changes, or if they were scheduled every three days and she would have to check the order. On 7/18/23 at approximately 1:45 PM, an interview was conducted with LPN C who was asked the importance of following a physician order for treatments, she stated that the dressings and treatments are like medications we have to follow the physician order. Wounds, if not cared for properly can become infected or worse. On 7/18/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	{F 658}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	{F 689}		8/31/23

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{F 689}	Continued From page 13 by: Based on observation, staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure 2 of 2 Resident care halls was safe and free of accident hazards. The findings included: The facility staff failed to ensure the Resident care areas within the facility were free of accident hazards, to include razors, cleaning products and over the counter medications, being accessible to Residents who are confused and wander. On 7/18/23 at 2:32 PM, Surveyors B and C made observations on both Resident care hallways. It was noted that in Resident rooms, multiple items were observed that could pose as a safety hazard to confused Residents. In one room there were 5 disposable razors on the sink, other rooms contained various items that could be hazardous to confused Residents. The items included but were not limited to a can of glade air freshener, rubbing alcohol, Lysol spray, pain reliving foot cream, Clorox wipes, etc. On the morning of 7/19/23, Resident #3 stated that when he returned from a recent hospitalization the facility staff had left a letter in his room listing various items they were not permitted to have. Resident #3 offered the survey team a copy of the letter. The letter stated, "Items that are prohibited from being kept at the Resident's bedside: Aerosol Sprays: air fresheners, cleaners/cleaning supplies, bug sprays, anything with a chemical/hazardous warning. Electrical Equipment..., Medical Supplies: ... rubbing alcohol, fingernail polish remover..., Medications: OTC medications...".	{F 689}	1.Resident #3 and Resident #18 did not have any injury related to the deficient practice. 2.All resident rooms were assessed for items such as disposable razors left out on sink, Clorox wipes, aerosol air fresheners, rubbing alcohols, Lysol spray, foot creams, OTC meds, pest sprays, etc. Items were removed from the rooms and families called to pick up items. All residents with BIMS of 9 or more were reminded about not being able to have these items in their room and why. 3.All residents with BIMS of 9 or more were reminded about not being able to have these items in their room and why by the Activities Director by 8/8/2023. Administrator mailed letter to the families to not bring in such items to the facility on 8/7/2023. Add letter to the admission packets to educate all new admits and families that residents cannot have these types of items out in the room and to not bring in the facility. Educate all the staff if see such items to remove from the room with the resident□s permission and remind them they cannot have such items and to turn the found item into the Administrator, education with staff by Administrator and designee by 8/8/2023. 4.Room rounds daily by department heads M-F to ensure compliance with items that are not allowed in room for safety reasons. Findings will be brought to the administrator in stand-up meeting or	

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{F 689}	Continued From page 14 On the afternoon of 7/19/23, an interview was conducted with Employee E, the activities director. Employee E stated that a Resident Council meeting was held on 7/10/23, and the Administrator discussed the letter [letter listing items not permitted that Resident #3 had provided the survey team]. Employee E said the Administrator explained that the facility had a duty to keep everyone safe and because the facility has Residents who wander, having these items in rooms could pose as a safety hazard to other Residents. On the afternoon of 7/19/23, the survey team interviewed Employee D, the admissions director. The Admissions Director was shown the facility letter regarding items Residents were not permitted to have. Employee D confirmed that they are in the process of making this part of the admissions package to discuss on admission. Employee D said that these items are not permitted because, "a confused Resident could wander into the room and ingest the items not knowing". On 7/19/23, Surveyor B interviewed the Administrator. The Administrator confirmed that the facility currently has one Resident [Resident #18] who is a wanderer. The Administrator confirmed that at times Resident #18 does go into other Resident rooms. Review of the clinical record for Resident #18 revealed an elopement risk assessment had been performed on 7/13/23 and identified Resident #18 as "disoriented daily" with "full mobility". This assessment scored Resident #18 as an elopement risk. Resident #18's care plan	{F 689}	stand down meeting M-F. The daily stand up/stand down sheet will be your audit tool. All findings will be reported to QAPI for 3 months. 5.DOC 8/31/2023	

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{F 689}	Continued From page 15 read, "... I am at risk for elopement related to cognition impairment and wandering". The associated interventions read, "redirect resident when exit seeking, wandering in the halls or going into other resident rooms...". On the afternoon of 7/19/23, Surveyor C and the Director of Nursing made observations on the Resident care unit. The Director of Nursing was shown the various items in Resident rooms, to include, razors, rubbing alcohol, etc. and the DON stated that these items could pose a risk to confused residents. On 7/19/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above concerns. The Administrator confirmed that they had identified such items as being hazardous and she had shared this with Residents during the Resident Council meeting held on 7/10/23. No further information was provided.	{F 689}		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to administer IV medications consistent with professional standards of practice and in	F 694	1.Resident #11 MD was notified of PICC being clogged on 7/19/2023 by the DON. No ill-effect on the resident.	8/31/23

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F 694 Continued From page 16

accordance with physician orders, for 1 Resident (# 11) in a survey sample of 20 Residents.

The findings included:

For Resident #11, the facility staff failed to initiate protocol for an occluded PICC (Peripherally Inserted Central Catheter) the Physician and the pharmacy IV team.

The following was entered into the progress notes:

"7/18/23 at 4:43 PM -PICC blue port unable to flush; red line patent right arm +3 pitted edema dsgs intact anxiety high T 98.1 ABX Role: NUR, Category: Nurses Notes, Significance: Medium."

On 7/19/23 at 1:30 PM, an interview was conducted with LPN D who stated that the purple port was clogged but that she was giving the antibiotics through the red port. When asked if the red port was typically used for lab draws, she indicated that it was, however she stated it was the only way to give the antibiotics since the other port was clogged.

On 7/19/23 at 1:45 PM, the DON and the Clinical Support Specialist were interviewed, and asked if they were aware of Resident #11's clogged port in her PICC line. The DON stated that she was not, and the Clinical Support Specialist also indicated that she was not aware. When asked if they should have been made aware of a problem with the PICC line, and both agreed they should have been notified immediately. When asked if the physician should have been notified, they agreed the physician or nurse practitioner should have been notified.

F 694

2.An audit was completed, no other residents have a PICC line in the facility.

3.The DON or assignee educated all nurses including agency on what to do if a PICC line is clogged. (Notify the MD, hold order if needed if resident does not have a double lumen, Notify the nurse manager on duty, document, carry out MD/NP order if order to call pharmacy for IV team to come and give activase) Education completed on 8/8/2023.

4.Any resident with PICC lines will be on high-risk rounds by the nurse manager to check daily to make sure the PICC lines are patent and report findings daily in the clinical morning meeting if there are issues noted. DON will monitor progress notes for documentation of issues with PICC lines in the clinical morning meeting. Any findings will be reported monthly to QAPI for the next 3 months.

5.DOC 8/31/2023

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F 694	Continued From page 17	F 694		

Continued From page 17

Surveyor accompanied the DON to speak with LPN D. The DON asked LPN D if there was a problem with the PICC line for Resident #11. LPN D stated, " The purple lumen is not patent it looks like someone tried to draw blood from it." LPN D tried to flush it and met resistance. She stated, "I was going to let LPN B know but haven't gotten to it yet." The DON explained to the Resident that the line was clogged, and they would have to call the IV team to get it unclogged.

After exiting Resident #11's room, Surveyor B asked the DON what the danger is with an occluded PICC line, and she stated if someone tries to flush the line and pushes too hard, it could cause a blood clot break off and enter the bloodstream (an embolism). The DON was asked what protocol is for an occluded line and she stated, "My next step is I'm going to notify the nurse practitioner that the line is clogged then she can order the Activase and then I will contact pharmacy, so they contact IV team."

The following is excerpts from the PICC Line policy and procedure provided to survey team.
Page 1 Paragraph 3
" Considerations:"
"Measure the circumference of the upper arm before insertion and at baseline when clinically indicated to assess for the presence of edema, and possible DVT deep vein thrombosis. measure 10 cm above insertion site."

"Measure external length of the PICC catheter; catheter only; not the hub, extension set or needleless connector at insertion. with each dressing change, and when clinically indicated if the catheter dislodgment is suspected compared

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F 694	Continued From page 18 to measurements obtained at insertion. The document did not address steps to take if a PICC line became occluded. On 7/20/23 at 11:00 AM, the DON was asked about an update on Resident's PICC line she stated that the Resident was doing fine, and the nurse practitioner had ordered the Activase, and the Pharmacy IV team would be in to unclog the port however they did not have an estimated time of arrival yet. On 7/20/23 the Administrator was made aware of the concerns and no further information was provided.	F 694		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	{F 755}		8/31/23

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{F 755}	Continued From page 19 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 Resident (#6) in a survey sample of 20 Residents. The findings included: For Resident #6 the facility staff failed to administer medications accurately and as ordered by the physician. On 7/18/23 during a count of the controlled medications on LPN C's cart, it was found that Resident #6's medication (liquid gabapentin) was incorrect. According to the controlled medication count sheet there should have been 73 ml (milliliters) in the bottle, however just looking at the bottle it was obvious that the medication came to just under the 100 ml mark. On 7/18/23 at approximately 1:00 PM, an	{F 755}	1.Resident #6 pain assessment was conducted on 7/18/2023. Resident had no ill effects of missed doses of Gabapentin. MD was notified of the overage of the liquid Gabapentin on 7/18/2023 by the DON. 2.All residents that receive controlled drugs narcotic sheets were checked for accuracy of subtraction, sheets were checked against the meds in the drawer to make sure the sheets were accurate with the meds available and what should have been given, and the MAR was checked for omissions of the documentation of the narcotic. All findings were reported to the MD. 3.All nurses including the agency educated on the counting of narcotics policy, making sure if a liquid med comes in and is more than what on the printed narcotic sheet shows that 2 nurses validate the amount and correct the sheet on arrival of this liquid medication, signing	

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{F 755}	Continued From page 20 interview was conducted with LPN C who stated she was not aware that the medication was off by so much. She said, "Well I guess it's better over than under." On 7/18/23 at approximately 1:15 PM, the clinical support specialist and the DON were made aware of the discrepancy in the medication and the controlled medication count sheet. The Clinical Support Specialist stated that the pharmacy sometimes overfills the bottles of medication. Surveyors explained that Resident #6 has orders for 2 ml of liquid gabapentin 3 times per day. That is 6 ml per day. The bottle contained 179 ml on 6/29/23 at 9 AM (after getting her first dose) and on 7/18/23 the controlled medication count sheet read that there were 73 ml left in the bottle. If Resident # 6 has orders for 2 ml 3 times per day (or 6 ml per day) and there are 19 days from 6/29/23 to 7/18/23 19 days X 6 /day =114 ml she should have received so far from the bottle. If you subtract 114 ml, from 179 ml you get 65 ml. The correct amount that should be on the sheet is 65 ml. When looking at the bottle is obvious it is closer to the 100 ml mark. The Clinical Support Specialist stated that the resident went out to the ER two times and didn't get her meds on 2 occasions. (This would account for 4 ml extra in the bottle) On 7/19/23 at 9:00 AM, the Clinical Nurse Specialist stated that there were some mathematical errors on the controlled medication sheet, and she had corrected them. She stated after one nurse made a mistake, the others just subtracted 2 from the count and the mistake continued. When asked if that was concerning,	{F 755}	off the meds on the MAR. Education completed by the DON or designed by 8/8/2023. 4.DON or designee will conduct weekly audits of the narcotic books to ensure accuracy of the meds being given as ordered. Results of audits will be reported to monthly QAPI for 3 months. 5.DOC 8/31/2023	

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{F 755}	Continued From page 21	{F 755}		

she stated that it was because no one was looking at the bottle to see the amount in the bottle did not match the sheet. She stated that after correcting the mathematical errors and then the sheet read 75 ml in the bottle, and when she measured the amount there was 93 ml in the bottle.

However, there should have only been 65 ml's in the bottle and since there were 93ml, then she did not get 28 ml of medication, that equals 12 missed doses (not including the 2 doses she missed at the hospital) of gabapentin in 19 days.

A review of the Controlled Substances policy read:

Page 1.
"8 Licensed Nurses are to count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty count together. They must document and report any discrepancies to the Director of Nursing.

9. The Director of Nursing shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility [sic] parties and shall give the Administrator a written report of such findings."

On 7/19/23 during the end of day meeting the administrator was made aware of the concerns and no further information was provided.

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		8/31/23

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant

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F 760	Continued From page 22 medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to ensure Residents are free from significant medication errors, for 2 Residents (#12 & #13) in a survey sample of 20 Residents The findings included: 1. For Resident #12 the facility staff failed to give medications per physician orders including medications for diabetes, glaucoma and hypertension, edema, and anti-coagulant. On 7/18/23 during clinical record review, it was noted that Resident #12 did not get most of her meds on 7/13/23. There was no note in the chart to say that she was out of the facility or hospitalized. According to the medical record the following medications were not administered: latanoprost 0.005 % eye drops [for glaucoma] - 1 drop in each eye QHS Order Date: 8/04/22 Start Date: 8/05/22. Not signed off as administered on 7/9/23 & 7/13/23. Amlodipine 5 mg [for hypertension] ORAL Once a morning everyday Order Date: 2/22/22 Start Date: 2/22/22. Not signed off as administered on 7/13/23. Lisinopril 10 mg [for hypertension] Once a morning everyday Order Date: 2/22/22 Start Date: 2/22/22. Not signed off as administered on 7/13/23.	F 760	1.Resident #12 had no ill effects from the omission of multiple medications not being signed off on 7/9 and 7/13. MD was notified of the holes on the MAR on 7/19/2023. Nurse that did not sign off the MAR was given 1-1 in-service by the DON on expectation of med pass compliance with signing off the MAR. Resident #13 had no ill effects from the omission of multiple medications being signed off on 7/1,7/3,7/4,7/5,7/8,7/9,7/12,7/13,7/14,7/15,7/17,7/18,7/19. MD was notified of the holes on the MAR on 7/19/2023. Nurse that did not sign off the MAR was given 1-1 in-service by the DON on expectation of med pass compliance with signing off the MAR. 2.All MARS for the month of June and July was reviewed for omissions. MD/NP was notified of any findings 7/19/2023. No ill effects to any of the residents related to the omissions. 3.All nurses including the agency educated on the expectations of signing off medications when administering and the policy on professional standards. Educated on the 5 rights. Education completed by the DON or designed by 8/8/2023. 4.Missing documentation report will be run daily by the DON to ensure that there is no omissions in the MAR. This will be	

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	495328	A. BUILDING ______ B. WING ______	R-C 07/20/2023

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F 760	Continued From page 23 Metformin 1,000 mg [for diabetes] ORAL Once a morning everyday Order Date: 2/22/22 Start Date: 2/22/22. Not signed off as administered on 7/13/23. Eliquis 2.5 mg tablet ORAL Twice daily everyday Order Date: 2/22/22 Start Date: 2/22/22. Not signed off as administered on 7/13/23. Tradjenta 5 mg tablet [for diabetes] ORAL Once a morning everyday Order Date: 2/22/22 Start Date: 2/22/22. Not signed off as administered on 7/13/23. Furosemide 20 mg [diuretic] give 1 Tablet by mouth every morning Order Date: 2/22/22 Start Date: 3/22/23. Not signed off as administered on 7/13/23. Metoprolol tartrate 50 mg tablet ORAL Twice daily everyday Order Date: 2/22/22 Not signed off as administered on 7/13/23. On 7/20/23 at approximately 10:00 AM RN B was asked about the med pass and why medications were not signed off. RN B stated, "I give all my Residents their meds. The Wi-Fi stops at the end of the hall. I think that's what happened. When asked what the procedure was for power outages, she stated we use paper MARS. When asked what she did when the computer didn't work, she stated she went back to the nurse's station and parked her med cart and ran the meds down the hall. She added, "Usually at the end of my shift I go through and sign off anything that's missing." 2. For Resident #13 the facility staff failed to	F 760	reviewed in the clinical morning meeting and all findings reported to monthly QAPI times 3 months. 5.DOC 8/31/2023	

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F 760	Continued From page 24	F 760		

administer medications as ordered by the physician to include medications for pain, sleep, and BPH (Benign Prostatic Hypertrophy).

On 7/18/23 at 2:39 PM, Resident #13 complained about not getting all his medications. He stated that he has meds for sleep and knee joint pain that he is not getting every day like he is supposed to.

On 7/19/23, a review of the clinical record revealed that Resident #13 was not getting his medications as ordered. The following medications were missed or unavailable in July per the MAR (Medication Administration Record) in the electronic health record system.

Unisom 25 mg. for sleep was not administered on 7/1, 7/3, 7/5, 7/8, 7/9, 7/13, and 7/14. A review of the progress notes revealed that the nurses were signing that the medication was unavailable or awaiting delivery from the pharmacy.

Glucosamine 500 mg (milligram) tablet 2 capsule(s) orally once Daily Order Date: 6/21/23 Start Date: 6/22/23.
The Glucosamine was for arthritis / joint pain. A review of the MAR revealed the Resident did not get his medications on 7/4, 7/5, 7/12, 7/15, 7/18, and 7/19. A review of the progress notes revealed that the nurses are writing medication unavailable or out of stock.

Voltaren Gel 1% apply to bilateral knees for knee pain twice daily - was not signed off as being administered on 7/17 There was no documentation in the chart about it.

Doxazosin 1 tablet(s) orally Every night at

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F 760	Continued From page 25 bedtime for BPH (Benign Prostatic Hypertrophy) Order Date: 6/21/23 Start Date: 6/22/23 - not signed off as being given on 7/6/23. Gabapentin 100 MG CAPSULE: Give 2 capsule(s) orally Three Times Daily. Order Date: 6/21/23 Start Date: 6/22/23. A review of the MAR revealed it was not signed off as being given on 7/6/23 at 2PM and 9PM and on 7/12 at 2 PM. On 7/19/23 at approximately 10:00 AM, RN B was asked about the med pass and why medications were not signed off. RN B stated, "I give all my Residents their meds. The Wi-Fi stops at the end of the hall. I think that's what happened. When asked what the procedure was for power outages, she stated we use paper MARS. When asked what she did when the computer didn't work, she stated she went back to the nurse's station and parked my cart and ran the meds down the hall. She added, "Usually at the end of my shift I go through and sign off anything that's missing." On 7/19/23 at 11:30 Employee C stated the pharmacy had installed the Ready Rx for the back up or stat meds. On 7/20/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 760		
{F 925} SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced	{F 925}		8/31/23

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{F 925}	Continued From page 26 by: Based on observation, Resident and staff interviews, and facility documentation review, the facility staff failed to maintain an effective pest control program affecting 2 of 2 Resident care hallways. The findings included: The facility staff failed to ensure the Resident rooms and hallways were free of flies and gnats. On 7/18/23, during the survey entrance conference, the facility Administrator was asked to provide pest control logs. On 7/18/23 at 2:32 PM, Surveyors B and C made observations on both Resident care hallways. It was noted that in Resident rooms, flies and gnats were flying around Residents and were observed on the bed linen, of multiple Residents. On 7/18/23, the survey team was provided a document titled, "weekly inspections for pest control". Maintenance filled out the forms and noted on 7/17/23, "ok" indicating all areas were free of pests. On 7/19/23 at 12:48 PM, Surveyors B and C made observations on the Resident care unit again. Observations were made of the lunch trays being distributed and it was noted that multiple flies were on the food cart. Flies and gnats were observed again in multiple Resident rooms on both hallways. Flies were seen flying around Resident's meal trays, on privacy curtains, on bed linen, and on Residents. On 7/19/23, during the morning, an interview was	{F 925}	1.Resident #3 had no ill effects of this deficient practice. New pest control contract completed on 8/4/2023 and have been to the building to exterminate the pests. 2.All rooms inspected for pests and log completed on findings on 8/4/2023. All rooms checked for food not in containers in rooms and placed in Ziploc bags or plastic containers to assist with decreasing the number of gnats and flies. Administrator to send letter to families if bring food to please have in a closed container, if bring in fresh fruits to please put in container with name and place in pantry in refrigerator. 3.Pest control siting log placed a nurses station for staff to log pests when seen (i.e. flies, gnats, spiders, etc.) Maintenance to check log M-F and initial when the extermination of the pest is complete. Education to all staff on this pest siting log completed by Administrator by 8/8/2023. Administrator to educate the maintenance man on pest siting log and expectations to check daily and take care of the siting immediately. Maintenance is to make daily rounds of rooms, kitchen, halls, pantries, and offices and log any pests that are seen and to call the exterminator until the pests are gone. Educated on expectation on 8/4/2023. 4.Maintenance director to bring pest log to QAPI monthly and discuss findings and results of extermination for the next 3	

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{F 925}	Continued From page 27 conducted with Resident #3. When asked about pests in the facility, Resident #3 indicated there is a problem with flies and gnats. Resident #3 indicated he had personally purchased items to help deter and catch flies and gnats that he had put in his room. On 7/19/23 at approximately 1PM, an interview was conducted with CNA D. When asked about pests, CNA D said, "We have a problem with flies and gnats. We try to keep things bagged up and covered". On 7/19/23 at approximately 1:30 PM, an interview was conducted with CNA B. When asked about pests, CNA B stated, "It has been a problem ever since I've been here". When asked how long she had been at the facility, CNA B said about a year. CNA B said, "It is mostly gnats in every room". When asked about the flies, CNA B said, "You should see when the meal trays come out". CNA B acknowledged that she is aware that the facility has someone come in and spray, but it isn't effective. On 7/19/23 at 3:23 PM, an interview was conducted with Employee F, the maintenance director. Employee F confirmed that he oversees the pest control within the facility. He went on to say that they have a contracted provider that comes monthly. In addition to the contracted pest control company, "I [the maintenance director] can treat ants, gnats and flies". When asked about the flies and gnats in the facility, the maintenance director said, "We have a lot of gnats and flies, the way the ventilation is, we don't have units that manage the halls. There is also a lot of food and fruit, they get into face creams and anything you leave open. Here, you can only	{F 925}	months. 5.DOC 8/31/2023	

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treat the top of the problem because you can't stop the food, from coming in and we can only use certain chemicals".

During the above conversation/interview, the maintenance director stated that they [the facility management], is "not satisfied with the current pest control vendor and I have gotten approval to go with someone local for service". The maintenance director said this is something he is "doing the leg work on" and doesn't currently have a contract with a new company yet. The maintenance director provided pest control logs, which did not have any information with regards to any pest sightings and what treatments were applied.

On 7/19/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above concerns.

On 7/20/23, the facility Administrator provided the survey team with a facility policy titled, "Pest Control". This policy read, "Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents...".

No additional information was provided.