STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/1/2023 through 8/2/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 8/1/23 through 8/2/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 40 certified bed facility was 40 at the time of the survey. The survey sample consisted of 13 current resident reviews and one closed record review.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		9/15/23

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

Electronically Signed | 08/11/2023

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review it was determined that the facility staff failed to implement the comprehensive care plan for one of 14 residents in the survey sample, Resident #7. The findings include:	F 656	F656, Care Plan 1. All Wander Guards were checked for proper function 2. All residents with Wander Guards have potential to be affected 3. Elopement Policy updated to include Wander Guard function checks and documentation, and staff educated.	

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F 656	Continued From page 2 For Resident #7 (R7), the facility staff failed to implement the comprehensive care plan to check functioning of a WanderGuard device (1) used to monitor the resident for elopement. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/1/2023, the resident was assessed as being moderately impaired for making daily decisions. Section E documented R7 displaying behaviors of rejection of care during the survey dates and not wandering during the assessment period. The comprehensive care plan for R7 documented in part, "(Name of R7) is a potential elopement risk/wanderer AEB (as evidenced by) Disoriented to place d/t (due to) recent admission r/t (related to) aging and her disease process. Date Initiated: 04/25/2023. Created on: 04/25/2023. Revision on: 04/25/2023." Under "Interventions/Tasks" it documented in part, "...WANDER ALERT: Check device as required to make sure it is working properly. Date Initiated: 04/25/2023. Created on: 04/25/2023. Revision on: 04/25/2023." The physician orders for R7 documented in part, "Wander Guard Bracelet for Safety every day shift for Safety, prevention of elopement. Order Date: 04/18/2023. Start Date: 04/25/2023." Review of the eTAR's (electronic treatment administration records) from 6/1/2023 through 8/1/2023 documented the Wander Guard Bracelet checked for placement each day, however there was no documentation that it was checked to ensure it was functioning. On 8/2/2023 at 11:19 a.m., an interview was	F 656	4. Administrator or designee will audit 3 residents monthly x 3 months to ensure compliance. Discrepancies will be corrected, and staff reeducated. Audit results will be tracked and reported to QAPI. 5. Sept 15, 2023	

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F 656	Continued From page 3	F 656		

conducted with RN (registered nurse) #1. RN #1 stated that the WanderGuards were checked for placement every day on the day shift. She stated that the staff did not check the device for function but if they felt that the device was not working properly they contacted maintenance to check the doors and fix it. She stated that they would know that the device was not working properly if the resident went to the doors and the alarms did not go off or lock. She stated that the purpose of the care plan was to know how to care for the resident and the staff implemented the care plan by going over it monthly in the meetings, reading the notes daily and reviewing the care plan. She stated that the care plan should be implemented so that the resident received good care that met his or her preferences.

On 8/2/2023 at 11:41 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that WanderGuards were checked by staff daily for placement only and the staff did not check them for function. She stated that if an issue was suspected they contacted maintenance who came to check the doors to make sure they were working properly. She stated that they were not aware of any elopements at the facility.

On 8/2/2023 at 11:53 a.m., an interview was conducted with OSM (other staff member) #3, maintenance supervisor. OSM #3 stated that when a resident required a WanderGuard they supplied them to the staff. OSM #3 stated that he went around the facility monthly and checked the door locks to make sure they functioned as intended. He stated that he had a hand held device that checked the magnetic field for door function but did not check the wander guard

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F 656	Continued From page 4 devices for function. He stated that the specific wander guards would not be checked unless there was a question whether they were working or not. The facility policy, "Procedure for Updating Care Plans" dated 5/17/2023 failed to evidence guidance on implementation of the care plan. On 8/2/2023 at 12:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, medical doctor were made aware of the concern. No further information was provided prior to exit. Reference: (1) A WanderGuard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts your caregivers. Even more important, when paired with optional magnetic door locks, the door automatically locks. When a caregiver needs to escort a wander-prone resident outside the safe area, the caregiver can use a secure code to bypass the system. The system also works in areas without physical doors. These virtual boundaries help a community feel welcoming without compromising safety. This information was obtained from the website: https://www.securitashealthcare.com/blog/3-reasons-you-need-wanderguard-system	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		9/15/23

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F 658	Continued From page 5 §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 interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for medication administration, for two of 14 residents in the survey sample, Resident #7 and Resident #8. The findings include: 1. For Resident #7 (R7), the facility staff failed to clarify the dosing of an as needed order for the pain medication, Morphine Sulfate (1) oral solution. On the most recent MDS (minimum data set), an admission assessment with an ARD (Assessment Reference Date) of 5/1/2023, the resident was assessed as being moderately impaired for making daily decisions. Section J documented R7 receiving scheduled pain medications during the assessment period. The physician orders for R7 documented in part, "Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (milligram per milliliter) (Morphine Sulfate) Give 1 dose orally every 4 hours as needed for moderate to severe pain rated 5-10 or if not taking po (by mouth) meds. Give 0.25ml or 0.50ml. Order Date: 07/04/2023. Start Date: 07/04/2023." Review of the eMAR (electronic medication	F 658	1. a. MD clarified morphine order on Aug 2, 2023 1. b. Digoxin order updated to include apical heart rate monitoring on Aug 3, 2023 2. All residents on digoxin or morphine have potential to be affected 3. a. Educate nurses to clarify morphine orders with ranges. 3. b. Educate nurses to assess apical heart rate prior to administration of digoxin 4. DON or Designee will audit 1 morphine order and 1 digoxin order per month x 3 months to ensure orders have been transcribed correctly, and to ensure proper monitoring. Discrepancies will be corrected, and staff reeducated. Audit results will be tracked and reported to QAPI.	

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administration record) dated 7/1/2023-7/31/2023 for R7 documented in part, "Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 1 dose orally every 4 hours as needed for pain Give 0.25ml or 0.50ml. -D/C (discontinue) Date- 07/04/2023 1021 (10:21 a.m.)." It was documented on the eMAR that R7 received one dose at 12:59 p.m. on 7/3/2023 for a pain level of 7.

Review of the eMAR (electronic medication administration record) dated 7/1/2023-7/31/2023 for R7 revealed in part, "Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 1 dose orally every 4 hours as needed for moderate to severe pain rated 5-10 or if not taking po meds Give 0.25ml or 0.50ml." It was documented on the eMAR that R7 received doses on 7/6/2023 at 7:08 p.m. for a pain level of 6, 7/7/2023 at 11:35 a.m. for a pain level of 8, at 8:00 p.m. for a pain level of 7, on 7/9/2023 at 5:07 a.m. for a pain level of 8, at 3:43 p.m. for a pain level of 7, on 7/10/2023 at 9:02 a.m. for a pain level of 8, on 7/11/2023 at 11:10 a.m. for a pain level of 8, on 7/13/2023 at 1:10 p.m. for a pain level of 8, on 7/17/2023 at 12:36 p.m. for a pain level of 8, on 7/22/2023 at 1:27 p.m. for a pain level of 6, on 7/23/2023 at 6:14 p.m. for a pain level of 8, on 7/24/2023 at 6:16 p.m. for a pain level of 8, and on 7/25/2023 at 6:32 a.m. for a pain level of 7.

The comprehensive care plan for R7 documented in part, "(Name of R7) is receiving a regularly scheduled pain medication for pain r/t (related to) previous back injury and multiple past surgeries. Date Initiated: 04/25/2023. Created on: 04/25/2023. Revision on: 04/25/2023."

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On 8/2/2023 at 11:19 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that as needed pain medications were administered according to the order and they normally had numerical parameters to administer them. She stated that normally the medications stated to give for pain between 1-6 or 6-10 and the nurse would use the pain assessment to determine which medication to give. RN #1 reviewed the physicians order for the as needed morphine sulfate for R7 and stated that they were not sure why it was written that way and they felt that the nurses would start with the lowest dosage first and then give the higher dosage as needed. She stated that the order left the dosing at the nurses discretion and that was not in the nursing scope of practice and the order should be clarified with the physician.

The facility policy "Medication Liberalization Policy" dated 5/4/2023 documented in part, "...The nurse shall administer medication in such a way that would promote the homelike environment and not interfere with resident life and comfort, while remaining within safe, evidence-based nursing parameters..."

On 8/2/2023 at 12:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, medical doctor were made aware of the findings.

No further information was presented prior to exit.

References:
(1) Morphine comes as a solution (liquid), an extended-release (long-acting) tablet, and as an extended-release (long-acting) capsule to take by mouth. The oral solution is usually taken every 4

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hours as needed for pain. MS Contin brand and Arymo ER brand are extended-release tablets that are usually taken every 8 or every 12 hours. Morphabond brand extended-release tablets are usually taken every 12 hours. Kadian brand extended-release capsules are usually taken with or without food every 12 hours or every 24 hours. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682133.html

2. For Resident #8 (R8), the facility staff failed to follow professional standards of medication administration to assess the heart rate prior to administration of Digoxin (1).

The physician orders for R8 documented in part, "Digoxin Oral Tablet 125 MCG (microgram) (Digoxin) Give 1 tablet by mouth every day shift related to Left Ventricular Failure, Unspecified. Order Date: 04/04/2023. Start Date: 04/13/2023."

Review of the eMAR (electronic medication administration record) dated 6/1/2023-6/30/2023 for R8 documented "Digoxin Oral Tablet 125 MCG (Digoxin) Give 1 tablet by mouth every day shift related to Left Ventricular Failure, Unspecified." The eMAR revealed documentation that the Digoxin was administered to R8 each day but failed to evidence a heart rate assessment prior to administration.

Review of the eMAR dated 7/1/2023-7/31/2023 for R8 revealed documentation that the Digoxin was administered to R8 each day but failed to evidence a heart rate assessment prior to

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administration.

Review of the eMAR dated 8/1/2023-8/31/2023 for R8 revealed documentation that the Digoxin was administered to R8 on 8/1/2023 and 8/2/2023 but failed to evidence a heart rate assessment prior to administration.

Review of the clinical record for R8 under "Pulse Summary" failed to evidence a pulse check on 6/1/2023, 6/2/2023, 6/4/2023-6/9/2023, 6/11/2023-6/16/2023, 6/18/2023-6/23/2023, 6/25/2023-6/30/2023, 7/2/2023-7/7/2023, 7/9/2023-7/13/2023, 7/17/2023-7/20/2023, 7/24/2023-7/28/2023 and 7/30/2023-8/2/2023.

The comprehensive care plan for R8 documented in part, "(Name of R8) is receiving regularly scheduled Digoxin Therapy r/t (related to) Left Ventricular Failure. Date Initiated: 04/12/2023. Created on: 04/12/2023. Revision on: 04/12/2023."

On 8/2/2023 at 11:19 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they were not aware of any specific assessments prior to administering Digoxin to a resident. When asked about assessing the heart rate prior to administering Digoxin to a resident, RN #1 stated that they monitored residents heart rates at least daily and it was documented in the computer under the vital signs. She stated that she did not think that the nurses always checked the heart rate prior to administration but checked it sometime during the day and would notify the physician and assess further if it were lower than 60.

On 8/2/2023 at 11:41 a.m., an interview was

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conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that they had asked the physician about the Digoxin administration and had added heart rate monitoring to the eMAR for the Digoxin because the physician said that it would not hurt anything to have it there but was not necessary. ASM #2 stated that they had a nursing drug reference book that the staff used for medication administration and would provide the book for review and they were not sure if assessing the heart rate prior to administration of Digoxin was a nursing standard of practice.

On 8/2/2023 at 11:50 a.m., an interview was conducted with ASM #3, medical doctor. ASM #3 stated that they were not aware that it was a expectation for nursing to assess the heart rate prior to administration of Digoxin and they felt that R8's pulse had not been an issue when they had reviewed the vital signs.

On 8/2/2023 at 12:37 p.m., ASM #2, the director of nursing provided "Nursing 2023 Drug Handbook" by Wolters Kluwer and stated it was the drug reference book used by nursing staff. ASM #2 stated that they had spoken with ASM #3, the medical doctor and they felt that the heart rate assessment was not necessary. At this time, a request was made for a professional standard of practice stating that the heart rate monitoring was at the physician's discretion.

Review of "Nursing 2023 Drug Handbook" by Wolters Kluwer provided by the facility documented on pages 433-437 in part, "Digoxin...Administration PO (by mouth) ...Before giving drug, take apical-radial pulse for 1 minute. Record and notify prescriber of significant

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F 658	Continued From page 11 changes (sudden increase or decrease in pulse rate, pulse deficit, irregular beats and, particularly, regularization of a previously irregular rhythm. If these occur, check BP (blood pressure) and obtain a 12-lead ECG (electrocardiogram)...Alert: Excessively slow pulse rate (60 beats/minute [bpm] or less) may be a sign of digitalis toxicity. Withhold the drug and notify prescriber..." On 8/2/2023 at 12:43 p.m., ASM #3, medical doctor, stated that they were unable to provide a reference regarding nursing not having to check a pulse before administering Digoxin. On 8/2/2023 at 12:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, medical doctor were made aware of the findings. No further information was presented prior to exit. Reference: (1) Digoxin is used to treat heart failure and abnormal heart rhythms (arrhythmias). It helps the heart work better and it helps control your heart rate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682301.html	F 658		
F 689 SS=E	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	F 689		9/15/23

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F 689	Continued From page 12 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to monitor the function of Wander Guards used for the prevention of elopements, for two of 14 residents in the survey sample, Resident #7 and Resident #8. The findings include: 1. For Resident #7 (R7), the facility staff failed to monitor the functioning of the WanderGuard device (1) used to monitor the resident for elopement. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/1/2023, the resident was assessed as being moderately impaired for making daily decisions. Section E documented R7 displaying behaviors of rejection of care during the survey dates and not wandering during the assessment period. The physician orders for R7 documented in part, "Wander Guard Bracelet for Safety every day shift for Safety, prevention of elopement. Order Date: 04/18/2023. Start Date: 04/25/2023." Review of the eTAR's (electronic treatment administration records) for R7 from 6/1/2023 through 8/1/2023 documented the Wander Guard Bracelet in place each day, however there was no documentation that it was checked to ensure it was functioning.	F 689	F689 Free of Accident/Hazards/Supervision 1. All Wander Guards were checked for proper function 2. All residents with Wander Guards have potential to be affected 3. Elopement Policy updated to include Wander Guard function checks and documentation, and staff educated. 4. Administrator or designee will audit 3 residents monthly x 3 months to ensure compliance. Discrepancies will be corrected, and staff reeducated. Audit results will be tracked and reported to QAPI.	

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The progress notes for R7 documented in part,
- "4/25/2023 13:23 (1:23 p.m.) ...Son/RR (resident representative) completed admission paperwork with DON (director of nursing). RR requesting to pick up copy of written plan care at later date when he returns to facility to visit his mother. RR states resident has been known to try leaving home and locks his doors so Resident cannot elope, RR thinks wanderguard bracelet is necessary for safety, Bracelet placed on resident's left wrist."
- "5/12/2023 09:58 (9:58 a.m.) ...Resident was brought out to be with staff, consumed small snack and sat in recliner for short period of time, then wandered halls with staff direct supervision safety. Resident stated that she was "going home" and "how do I get out of here?" Explained that she was going to stay here for now and provided the hour of the night. Resident just continued to wander with staff at her side..."
- "6/10/2023 22:59 (10:59 p.m.) Note Text :Resident ROM (range of motion) per usual this shift. Resident wandered facility per usual and had interactions with staff often during this shift."

A "Wandering Risk Evaluation" for R7 dated 4/25/2023 documented the resident having a history of wandering and being a high risk for wandering.

The comprehensive care plan for R7 documented in part, "(Name of R7) is a potential elopement risk/wanderer AEB (as evidenced by) Disoriented to place d/t (due to) recent admission r/t (related to) aging and her disease process. Date Initiated: 04/25/2023. Created on: 04/25/2023. Revision on: 04/25/2023."

On 8/2/2023 at 11:19 a.m., an interview was

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conducted with RN (registered nurse) #1. RN #1 stated that the WanderGuards were checked for placement every day on the day shift. She stated that the staff did not check the device for function but if they felt that the device was not working properly they contacted maintenance to check the doors and fix it. She stated that they would know that the device was not working properly if the resident went to the doors and the alarms did not go off or lock.

On 8/2/2023 at 11:41 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that WanderGuards were checked by staff daily for placement only and the staff did not check them for function. She stated that if an issue was suspected they contacted maintenance who came to check the doors to make sure they were working properly. She stated that they were not aware of any elopements at the facility.

On 8/2/2023 at 11:53 a.m., an interview was conducted with OSM (other staff member) #3, maintenance supervisor. OSM #3 stated that when a resident required a WanderGuard they supplied them to the staff. OSM #3 stated that he went around the facility monthly and checked the door locks to make sure they functioned as intended. He stated that he had a hand held device that checked the magnetic field for door function but did not check the wander guard devices for function. He stated that the specific wander guards would not be checked unless there was a question whether they were working or not.

On 8/2/2023 at 12:40 p.m., ASM #1, the administrator stated that the facility had a routine

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TAR (treatment administration record) check for WanderGuard placement but not a specific policy for Wander Guard function.

On 8/2/2023 at 12:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, medical doctor were made aware of the concern.

No further information was provided prior to exit.

Reference:
(1) A WanderGuard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts your caregivers. Even more important, when paired with optional magnetic door locks, the door automatically locks. When a caregiver needs to escort a wander-prone resident outside the safe area, the caregiver can use a secure code to bypass the system. The system also works in areas without physical doors. These virtual boundaries help a community feel welcoming without compromising safety. This information was obtained from the website: https://www.securitashealthcare.com/blog/3-reasons-you-need-wanderguard-system

2. For Resident #8 (R8), the facility staff failed to monitor the functioning of the WanderGuard device used to monitor the resident for elopement.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/18/2023, the resident scored

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5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section E documented R8 not displaying any wandering behaviors during the assessment period.

The physician orders for R8 documented in part, "Check Wanderguard bracelet for placement. every day shift for Wandering. Order Date: 04/12/2023. Start Date: 04/13/2023."

Review of the eTAR's (electronic treatment administration records) for R8 from 6/1/2023 through 8/1/2023 documented the Wander Guard Bracelet in place each day, however there was no documentation that it was checked to ensure it was functioning.

The progress notes for R8 documented in part,
- "4/14/2023 06:09 (6:09 a.m.) Note Text : New admit note. Resident did not sleep most of the night and wanted to wander. She was redirectable and pleasant..."
- "4/18/2023 23:17 (11:17 p.m.) Note Text : Day 7/7 new admit. Resident confused and exit seeking this shift. Stated someone was coming for her and she did not want to miss her ride."

A "Wandering Risk Evaluation" for R8 dated 4/12/2023 documented the resident having a history of wandering and being a high risk for wandering.

The comprehensive care plan for R8 documented in part, "(Name of R8) is an elopement risk/wanderer AEB (as evidenced by) Impaired safety awareness r/t (related to) her disease process. Date Initiated: 04/13/2023. Created on:

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04/13/2023. Revision on: 04/13/2023."

On 8/2/2023 at 11:19 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the WanderGuards were checked for placement every day on the day shift. She stated that the staff did not check the device for function but if they felt that the device was not working properly they contacted maintenance to check the doors and fix it. She stated that they would know that the device was not working properly if the resident went to the doors and the alarms did not go off or lock.

On 8/2/2023 at 11:41 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that WanderGuards were checked by staff daily for placement only and the staff did not check them for function. She stated that if an issue was suspected they contacted maintenance who came to check the doors to make sure they were working properly. She stated that they were not aware of any elopements at the facility.

On 8/2/2023 at 11:53 a.m., an interview was conducted with OSM (other staff member) #3, maintenance supervisor. OSM #3 stated that when a resident required a WanderGuard they supplied them to the staff. OSM #3 stated that he went around the facility monthly and checked the door locks to make sure they functioned as intended. He stated that he had a hand held device that checked the magnetic field for door function but did not check the wander guard devices for function. He stated that the specific wander guards would not be checked unless there was a question whether they were working or not.

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F 689	Continued From page 18 On 8/2/2023 at 12:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, medical doctor were made aware of the concern. No further information was provided prior to exit.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		9/15/23

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F 732	Continued From page 19 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to post complete nurse staffing information for two of two days reviewed. The findings include: The facility staff failed to post the total number of RNs (registered nurses), LPNs (licensed practical nurses) and CNAs (certified nursing assistants) directly responsible for resident care per shift on 8/1/23 and 8/2/23. A review of the nurse staffing information postings for 8/1/23 and 8/2/23 failed to reveal documentation of the total number of RNs, LPNs and CNAs directly responsible for resident care per shift (the postings only documented hours worked). On 8/2/23 at 10:14 a.m., an interview was conducted with OSM (other staff member) #1 (administrative assistant). OSM #1 stated the nurse staffing information postings document the census and the amount of RN, LPN and CNA hours worked for each shift. OSM #1 stated she was not aware that the total number of RNs, LPNs and CNAs for each shift should be documented on the postings.	F 732	F732 Posted Nurse Staffing 1. Posting matrix was corrected Aug 3, 20223 2. All residents have potential to be affected. 3. Updated policy to include number of people per shift, and staff have been educated. 4. Administrator or Designee will monitor posting weekly x 4 week, and monthly x 2 months. Discrepancies will be corrected, and staff reeducated. Audit results will be tracked and reported to QAPI.	

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F 732	Continued From page 20 On 8/2/23 at 12:49 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Nurse Staffing Posting Information" documented, "1. The Daily Staffing Sheet will be posted and contain the following information: a. Facility name b. Current date c. Current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides/Nurse Aide..."	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		9/15/23

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F 757	Continued From page 21 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to adequately monitor a resident prior to administering a medication, for one of 14 residents in the survey sample, Resident #8. The findings include: For Resident #8 (R8), the facility staff failed to assess the heart rate prior to administration of Digoxin (1). The physician orders for R8 documented in part, "Digoxin Oral Tablet 125 MCG (microgram) (Digoxin) Give 1 tablet by mouth every day shift related to Left Ventricular Failure, Unspecified. Order Date: 04/04/2023. Start Date: 04/13/2023." Review of the eMAR (electronic medication administration record) dated 6/1/2023-6/30/2023 for R8 documented "Digoxin Oral Tablet 125 MCG (Digoxin) Give 1 tablet by mouth every day shift related to Left Ventricular Failure, Unspecified." The eMAR revealed documentation that the Digoxin was administered to R8 each day but failed to evidence a heart rate assessment prior to administration.	F 757	1. Digoxin order updated to include apical heart rate monitoring on Aug 3, 2023 2. All residents on digoxin have potential to be affected 3. Educate nurses to assess apical heart rate prior to administration of digoxin 4. DON or Designee will audit 1 digoxin order per month x 3 months to ensure proper monitoring. Discrepancies will be corrected, and staff reeducated. Audit results will be tracked and reported to QAPI.	

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Review of the eMAR dated 7/1/2023-7/31/2023 for R8 revealed documentation that the Digoxin was administered to R8 each day but failed to evidence a heart rate assessment prior to administration.

Review of the eMAR dated 8/1/2023-8/31/2023 for R8 revealed documentation that the Digoxin was administered to R8 on 8/1/2023 and 8/2/2023 but failed to evidence a heart rate assessment prior to administration.

Review of the clinical record for R8 under "Pulse Summary" failed to evidence a pulse check on 6/1/2023, 6/2/2023, 6/4/2023-6/9/2023, 6/11/2023-6/16/2023, 6/18/2023-6/23/2023, 6/25/2023-6/30/2023, 7/2/2023-7/7/2023, 7/9/2023-7/13/2023, 7/17/2023-7/20/2023, 7/24/2023-7/28/2023 and 7/30/2023-8/2/2023.

The comprehensive care plan for R8 documented in part, "(Name of R8) is receiving regularly scheduled Digoxin Therapy r/t (related to) Left Ventricular Failure. Date Initiated: 04/12/2023. Created on: 04/12/2023. Revision on: 04/12/2023."

On 8/2/2023 at 11:19 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they were not aware of any specific assessments prior to administering Digoxin to a resident. When asked about assessing the heart rate prior to administering Digoxin to a resident, RN #1 stated that they monitored residents heart rates at least daily and it was documented in the computer under the vital signs. She stated that she did not think that the nurses always checked the heart rate prior to administration but checked it sometime during the day and would notify the

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physician and assess further if it were lower than 60.

On 8/2/2023 at 11:41 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that they had asked the physician about the Digoxin administration and had added heart rate monitoring to the eMAR for the Digoxin because the physician said that it would not hurt anything to have it there but was not necessary. ASM #2 stated that they had a nursing drug reference book that the staff used for medication administration and would provide the book for review and they were not sure if assessing the heart rate prior to administration of Digoxin was a nursing standard of practice.

On 8/2/2023 at 11:50 a.m., an interview was conducted with ASM #3, medical doctor. ASM #3 stated that they were not aware that it was a expectation for nursing to assess the heart rate prior to administration of Digoxin and they felt that R8's pulse had not been an issue when they had reviewed the vital signs.

On 8/2/2023 at 12:37 p.m., ASM #2, the director of nursing provided "Nursing 2023 Drug Handbook" by Wolters Kluwer and stated it was the drug reference book used by nursing staff. ASM #2 stated that they had spoken with ASM #3, the medical doctor and they felt that the heart rate assessment was not necessary. At this time, a request was made for a professional standard of practice stating that the heart rate monitoring was at the physician's discretion.

Review of "Nursing 2023 Drug Handbook" by Wolters Kluwer provided by the facility

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F 757	Continued From page 24 documented on pages 433-437 in part, "Digoxin...Administration PO (by mouth) ...Before giving drug, take apical-radial pulse for 1 minute. Record and notify prescriber of significant changes (sudden increase or decrease in pulse rate, pulse deficit, irregular beats and, particularly, regularization of a previously irregular rhythm. If these occur, check BP (blood pressure) and obtain a 12-lead ECG (electrocardiogram)...Alert: Excessively slow pulse rate (60 beats/minute [bpm] or less) may be a sign of digitalis toxicity. Withhold the drug and notify prescriber..." On 8/2/2023 at 12:43 p.m., ASM #3, medical doctor, stated that they were unable to provide a reference regarding nursing not having to check a pulse before administering Digoxin. On 8/2/2023 at 12:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, medical doctor were made aware of the findings. No further information was presented prior to exit. Reference: (1) Digoxin is used to treat heart failure and abnormal heart rhythms (arrhythmias). It helps the heart work better and it helps control your heart rate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682301.html	F 757		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance.	F 868		8/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 868	Continued From page 25 §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the required QAPI (quality assurance and performance improvement) committee members	F 868	F868 QAA Committee 1. DON has been educated on QA meeting attendance 2. No residents were affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 868	Continued From page 26 attended the QAPI meeting for one of four quarterly meetings in 2022. The findings include: The facility staff failed to ensure the Director of Nursing attended the second quarter QAPI meeting on 7/25/22. A review of the 7/25/22 QAPI meeting sign-in sheet failed to reveal the signature of the Director of Nursing. On 8/2/23 at 8:31 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated QAPI meetings are held quarterly, and the Director of Nursing is supposed to attend. ASM #1 stated the former Director of Nursing did not attend the 7/25/22 QAPI meeting because he was on vacation. On 8/2/23 at 12:49 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Quality Assurance and Performance Improvement" documented, "2. The QA (quality assurance) Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The director of nursing services... b. Meet at least quarterly..."	F 868	3. DON has been educated on QA meeting attendance 4. Administrator or Designee will audit QA attendance sheets quarterly x 2 quarters. Audit results will be tracked and reported to QAPI.	