STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335023	A. Building B. Wing	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Holly Patterson Extended Care Facility	875 Jerusalem Avenue Uniondale, NY 11553

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on record reviews and staff interviews during the Recertification Survey initiated on 3/1/2022 and completed on 3/9/2022 the facility failed to ensure that the resident's environment was free of accident hazards for one (Resident #220) of 4 residents reviewed for accidents. Specifically, Resident #220 with a known history of Polysubstance abuse, was not supervised to prevent the availability of non-prescribed illicit drug usage within the facility. Resident #220 was readmitted to the facility on [DATE]. A Psychosocial assessment dated [DATE] documented the resident was utilizing and selling illicit drugs in the previous nursing facility. The current facility did not develop care plan interventions to monitor and supervise the resident for substance abuse. On 12/13/2021 Resident #220 was found unresponsive and transferred to hospital for opioid drug overdose. The facility did not initiate an investigation after the 12/13/2021 incident. The hospital discharge recommendations were to provide supervised visits. The facility did not address and re-assess the interventions to monitor and prevent the resident from obtaining illicit drugs. Subsequently, on 3/2/2022 the resident was found unresponsive and sent to hospital with diagnosis of drug overdose. The resident reported to the emergency room Physician that they (Resident #220) snorted heroin and passed out. Additionally, the facility did not have a system in place to identify and monitor residents with history of drug abuse. This resulted in actual harm to Resident #220 with potential for serious harm for 64 residents with history of drug abuse that is Immediate Jeopardy and Substandard Quality of Care. The finding is: The facility Contraband policy and procedure dated 11/2021 documented in order to ensure a safe environment, all residents presenting to the facility will be subject to a search directed towards identifying contraband and preventing its entrance into the facility. The policy defined contraband as items of danger including illegal substances. The procedure documented that all residents who enter the facility will be subjected to search if any suspected, or any evidence of having contraband. If a resident is found to have controlled substances during their stay, the staff member who finds the controlled substances will bring this to the attention of the attending in charge and the nurse in charge. Visitors who bring contraband into the facility may be asked to leave and may be denied visiting privileges in the future. The resident involved may become subject to a repeat search with confiscation or checking of objects as described above. The facility did not have a documented Policy and Procedure for management of residents with diagnosis of Substance Abuse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #220 was admitted with diagnoses of Polysubstance Abuse, Anxiety Disorder, Depression and status post Laminectomy. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #220 required limited assistance of one-person with locomotion in the resident's room. The locomotion off the unit did not occur in seven days of the MDS look back period. The MDS documented the resident was feeling depressed, or hopeless, and had disturbed sleep. The Quarterly MDS assessment dated [DATE] documented Resident #220 had a BIMS score of 15, indicating intact cognition. The MDS further documented Resident #220 required supervision without physical help from staff for locomotion on and off the unit. The resident was feeling depressed, or hopeless, and had disturbed sleep. The resident exhibited behavioral symptoms that were not directed towards others in four to six days in the last 7 day look back period of the MDS. The psychosocial assessment dated [DATE] documented Resident #220 was at another skilled nursing facility for 2 years for their back issues and was kicked out of previous facility for using and selling heroin, fentanyl and cocaine. The psychosocial assessment documented that Resident #220's judgement was poor. Resident #220 was noted to be anxious, impulsive, easily agitated, and disregarded rules. The history of polysubstance abuse care plan dated 9/28/2021 documented that Resident #220 was kicked out of a previous skilled nursing facility for using and selling heroin, fentanyl and cocaine. Resident #220 knew what was done was wrong and will not do that in the current facility. The goal included that Resident #220 will not use or sell illegal substances. The interventions included to encourage participation in activities of interest, social work one to one visits for emotional support and counselling as needed, psychiatric consultation, and psychological services follow up as needed. The Nursing Progress Note from 9/23/2021 through 12/12/2021 were reviewed and indicated no documented behaviors related to consuming or selling illicit drugs. The Situation Background Assessment Recommendation (SBAR) Communication Form dated 12/13/2021 documented Resident #220 had a change in condition with symptoms of altered mental status. The SBAR documented Resident #220 presented with altered level of consciousness, weakness, and shortness of breath. Around 9:00 PM, Resident #220 was observed sitting in the chair very lethargic with alteration in consciousness and was transferred to the hospital. The hospital record dated 12/13/2021 documented that Resident #220 was admitted to the hospital for altered mental status with Acute Hypoxic Respiratory Failure secondary to drug overdose (cocaine, opiate and benzodiazepine) with moderate improvement after Narcan 2 milligram (mg) injection. As per Emergency Medical Service (EMS) the oxygen saturation rate for Resident #220 was 82% (normal 95% or above) on room air at the Skilled Nursing Facility and was Hypotensive (low blood pressure). The hospital discharge summary dated 12/15/2021 documented a note to the Skilled Nursing Facility: supervised visiting only. Resident #220 has been receiving drugs from outside visitors and subsequently overdosed. There was no documented evidence of an investigation to determine the root cause of Resident #220's opiate overdose nor where and how the resident received the drugs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Nursing Admission/Readmission note dated 12/16/2021 documented that Resident #220 was admitted from the hospital at 7:40 PM. The resident was to only have supervised visitation. The Social Work note dated 12/16/2021 documented Resident #220 stated that a visitor brought the drugs to the building. Resident #220 stated that they took the visitor's phone number out of their phone and will not do it again. The Social Worker re-educated Resident #220 about not to smoke or vape in the facility. The history of polysubstance abuse care plan dated 9/28/2021 was not updated after the resident had returned from the hospital on 12/16/2021 with a diagnosis of drug overdose. A document titled Resident Delivery Searches dated 12/2021 documented that when a delivery comes to the facility for any of the following residents, the deliveries are to be searched for contraband. The list of names included Resident #220. The Physician readmission note dated 12/17/2021 documented Resident #220 had a past medical history of Polysubstance Abuse. Resident #220 was admitted on [DATE] [to the hospital] for altered mental status with Acute Hypoxic Respiratory Failure secondary to drug overdose (cocaine, opiate and benzodiazepine) with moderate improvement after Narcan 2mg injection. The assessment and plan included to continue current medications, provide safe environment, adequate nutrition, and supportive care. Monitor fingerstick, GI follow up for hepatic mass and psychiatry follow up. The Physician did not acknowledge the recommendation from the hospital related to supervised visitation for Resident #220. The Social Work note dated 1/4/2022 documented Resident #220 was moving from Unit 22 to Unit 46. Resident #220 was educated about not smoking or vaping in the facility. The Physician's note dated 1/12/2022 documented that Resident #220 has not had any acute events. The assessment and plan included to provide current medications, provide safe environment, adequate nutrition, and supportive care. The Physician did not acknowledge the recommendation from the hospital related to supervised visitation for Resident #220. The physician's note dated 2/9/22 documented that Resident #220 has not had any acute events and Resident #220 was able to transfer out of bed to ambulate by pushing the wheelchair independently. The physician documented that Resident #220 has a history of Anxiety that is controlled with Xanax. Psychiatry recommended to decrease Xanax and Resident #220 gets very agitated and violent when you try to discuss tapering of the Xanax. Resident #220 is on Cymbalta, Oxycodone and Baclofen for chronic back pain. Will decrease Cymbalta and discontinue Baclofen and follow up with Psychiatry regularly. The assessment and plan included to provide current medications, provide safe environment, adequate nutrition, and supportive care. Continue 2 liters of oxygen via nasal cannula. Nursing progress notes from 2/1/2022 to 3/2/2022 were reviewed. There was no documented evidence that the resident was being monitored or supervised for drug seeking behavior, attempts to sell illicit drugs, or consumption of illicit drugs prior to 3/2/2022. The December 2021 to March 2022 Certified Nursing Assistant (CNA) Accountability Records documented Resident #220 had a diagnosis of Polysubstance abuse. The CNA Accountability Records documented that Resident #220 could push the wheelchair independently. There was no documented evidence that the resident was to have supervision or monitoring related to Polysubstance abuse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The SBAR Communication Form dated 3/2/2022 documented Resident #220 had a change in condition. At 6:00 PM, Resident #220 was unresponsive to verbal and tactile stimuli. The SBAR documented oxygen saturation level of 66% when on oxygen at 3 liters per minute. Resident #220 was transferred to the hospital. The hospital record dated 3/2/2022 documented Resident #220 was transferred from the Skilled Nursing Facility for altered mental status. Resident #220 was brought in by EMS from the Skilled Nursing Facility for possible overdose. Narcan 2mg was administered intramuscularly by EMS. Resident #220 stated that they (Resident #220) snorted some Heroin and passed out. Resident #220 had an admission three months ago in December [2021] for a similar overdose. Resident #220 was admitted to the hospital for altered mental status secondary to opioid intoxication. The urine toxicology report was positive for opiates and benzodiazepines. The attending physician at the hospital diagnosed Resident #220 with toxic encephalopathy secondary to opioid intoxication and Substance abuse. Certified Nursing Assistant (CNA) #8 was interviewed on 3/03/2022 at 2:17 PM and stated they (CNA #8) were the regularly assigned CNA for the 7AM to 3PM shift for Resident #220 for the past two months. CNA #8 stated Resident #220 propelled their wheelchair throughout the facility and sometimes went downstairs to the vending machine. Resident #220 did not have any specific instructions to be monitored. CNA #8 stated that Resident #220 was independent in self-care and mobility and did not require any oversight. CNA #8 stated that they have not received any instructions to look through Resident #220's belongings to check for substance abuse related materials. CNA #8 was not aware if Resident #220 had any visitors on 3/2/2022 or even in the past month. CNA #8 further stated that there were no special instructions to monitor Resident #220 for substance abuse behaviors and there was no direction provided to supervise the resident throughout the facility. Registered Nurse (RN #7) was interviewed on 3/3/2022 at 2:20 PM. RN #7 stated that they (RN #7) were the regular 7AM to 3PM shift Unit Nurse for Resident #220's unit and has known Resident #220 since the resident was transferred to the unit two months ago. RN #7 stated that the staff did not have any specific instructions for monitoring Resident #220's whereabouts in the facility or for supervised visits. RN #7 was not aware if Resident #220 had any visits on 3/2/2022. RN #7 stated that they were aware of Resident #220's history of Substance abuse but thought it was a long time ago. RN #7 was not aware of Resident #220's overdose in the facility in December 2021. RN #7 further stated they (RN #7) did not receive any instructions to look through Resident #220's belongings to check for substance abuse related materials. CNA #9 was interviewed on 3/3/2022 at 3:15 PM and stated that they (CNA #9) were the assigned CNA for Resident #220 on the 3 PM -11 PM nursing shift on 3/2/2022. CNA #9 stated that the regularly assigned CNA was on vacation as of 3/2/2022. Resident #220 was able to independently propel their wheelchair throughout the facility without supervision. CNA #9 stated that they last saw Resident #220 at 4:30 PM in their room on 3/2/2022. Resident #220 was in the room and was talking. CNA #9 was called over by RN #8 who discovered Resident #220 unresponsive in their room at 5:00 PM. CNA #9 stated that they did not have any instructions for monitoring the resident for substance abuse behaviors and was not aware of Resident #220's history of drug overdose at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA #10 was interviewed on 3/3/2022 at 3:20 PM and stated that they (CNA #10) were the regularly assigned CNA on the 11:00 PM to 7:00 AM nursing shift for the past two months for Resident #220. CNA #10 stated that Resident #220 was usually in bed sleeping or watching television when they (CNA #10) started the 11:00 PM to 7:00 AM shift. CNA #10 stated they rarely went into Resident #220's room because Resident #220 was able to care for themself. CNA #10 stated that there was nothing on the CNA accountability record that instructed the CNAs to monitor the resident for drug abuse behavior. CNA #10 further stated they (CNA #10) were not aware of Resident #220's overdose and illicit drug use in the facility. RN #10 was interviewed on 3/3/2022 at 3:26 PM and stated that they (RN #10) were the RN Supervisor on 3/2/2022 on the 11 PM-7AM nursing shift and was covering the 3 PM-11 PM nursing shift on Resident #220's unit. RN #10 stated that they were called by RN #8 to Resident #220's room because Resident #220 presented with an altered mental status and was not waking up. Resident #220's oxygen saturation level was 66% and oxygen was being administered. The oxygen saturation level went up to 90-92%. RN #10 was aware of Resident #220's overdose in December 2021 but did not suspect that the resident had a drug overdose in this case. RN #10 did not tell the EMS anything about Resident #220's drug abuse behavior. RN #8 was interviewed on 3/3/2022 at 3:52 PM and stated that they (RN #8) were covering the 3PM-11PM nursing shift on 3/2/2022. RN #8 stated they were not the regularly assigned nurse for the resident's unit. RN #8 stated they (RN #8) were not aware that Resident #220 had substance abuse behaviors and had overdosed in December 2021 in the facility. RN #8 stated that there were no Physician's orders or instructions related to substance abuse monitoring for Resident #220. At the beginning of the shift Resident #220 was talking and seemed to be their usual self. RN #8 stated that they (RN #8) were not sure if Resident #220 left their bedroom at all during the shift. RN #8 stated that they (RN #8) did not see any visitors for Resident #220 during that shift nor did the Resident Care Associate (RCA) come to escort Resident #220 for a visit. At 5:00 PM, RN #8 went to Resident #220's room and Resident #220 seemed out of it. RN #8 stated they knew Resident #220 had a diagnosis of Diabetes and thought Resident #220 was in Diabetic shock. RN #8 did a fingerstick to check the blood sugar level which was 258 which did not indicate Diabetic shock. RN #8 stated they called RN #10 and continued to try to get Resident #220 to respond. When RN #10 arrived on the unit, RN #8 reported the resident's condition to RN #10. Resident #220 was transferred to hospital due to the unresponsiveness. Social Worker (SW) #2 was interviewed on 3/3/2022 at 5:11 PM and stated that they (SW #2) were the assigned SW for Resident #220 when the resident was admitted in September 2021. SW #2 stated they were aware that Resident #220 had a history of Substance abuse. SW #2 stated that residents with a known history of Substance abuse problems are referred to psychology and their incoming packages are to be checked for illicit drugs. SW #2 stated that searching packages is a standard protocol in the facility and did not have to be in a care plan. The nursing staff are expected to look through food items brought in from outside as per facility wide protocol. SW #2 stated that they (SW #2) believed that Resident #220 was not actively having Substance abuse disorder so a care plan to prevent and monitor substance abuse behavior was not developed. SW #2 stated that the facility cannot always search Resident #220's belongings and there's only so much they can do. SW #2 stated that Resident #220 was placed on SW #1's caseload when the resident was readmitted from the hospital on 12/16/2021 and that it was SW #1's responsibility to develop a care plan to address Resident #220's substance abuse behavior. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	SW #1 was interviewed on 3/3/2022 at 5:51 PM. SW #1 stated that they were assigned to Resident #220 upon their readmission in December 2021 after the resident returned from the hospital from the opiate overdose. SW #1 stated that they did not complete a psychosocial assessment and did not develop a revised plan of care to address Resident #220's Substance abuse behavior. SW #1 could not recall reviewing the hospital discharge paperwork with the instruction for supervised visitation to reduce Substance abuse behavior. SW #1 stated that an interdisciplinary team approach was not used to address Resident #220's Substance abuse behavior. Resident #220 was reassigned to SW #2 on 1/4/2022. The Medical Director and Director of Nursing were interviewed concurrently on 3/3/2022 at 6:30 PM. The Medical Director stated that Resident #220's diagnosis of Poly Substance Abuse is noted on the medical record and the staff are aware of Resident #220's history. The Director of Nursing stated that there is a system in place to monitor Resident #220 and it is the facility wide protocol to check packages and to supervise visits for all residents in the auditorium. The Director of Nursing stated that everyone on the interdisciplinary team is aware of Resident #220's smoking behavior and the substance abuse history is noted in the medical record. The Medical Director stated that Resident #220's name is on the list at the entrance way for security to search any packages that came from the outside. The facility wide protocol is that the Social Worker, Recreation Aide, and Security are to look through incoming food and packages for any hazardous materials. The Director of Nursing stated that room searches are only done if a staff member suspected that a resident was smoking and that the facility cannot do more than that. The Medical Director and the Director of Nursing stated that Resident #220 has not had any visitors. The Director of Nursing stated that the facility did not initiate an Incident Report to investigate how Resident #220 obtained drugs in the facility on 12/13/2021 because SW #2 had written a note that Resident #220 received the drugs from a visitor. The Director of Nursing stated that Resident #220 did not require increased supervision. The Director of Nursing further stated that the protocols were facility wide and did not need to be documented in a care plan. Attending Physician #2 was interviewed on 3/4/2022 at 3:42 PM and stated that they (Attending Physician #2) provided care for Resident #220 since Resident #220 was moved to Unit 46 on 1/4/2022. Attending Physician #2 stated that Resident #220 required monitoring and supervision and they (Attending Physician #2) had verbally informed CNA #10 and RN #7 to monitor Resident #220 for Substance abuse behavior. Attending Physician #2 stated that they did not recall documenting the need for increased monitoring for Substance abuse behaviors or placing an order instructing nurses to do so. SW #2 was re-interviewed on 3/4/2022 at 5:15 PM. SW #2 stated that the facility staff located Resident #220's care plan entitled history of substance abuse which was dated 9/28/2021. The interventions did not include to monitor and supervise Resident #220's whereabouts in the facility for substance abuse behavior. SW #2 stated that they had developed the care plan but did not revise the care plan after the resident returned from the hospital on 12/16/2021 since that was the responsibility of SW #1. Resident #220 should have had a revised care plan after the 12/13/2021 hospitalization . The care plan did not include any updates in December 2021. Resident #220 was not on the radar for active use of drugs at the time of the 9/28/2021 care plan. The search of packages is a standard practice for any resident in the facility so that intervention would not be in the care plan. 415.12(h)(1) The facility was notified of the Immediate Jeopardy on 3/3/2022. The Immediate Jeopardy was removed on 3/7/2022 prior to the completion of the survey. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The facility created policies and procedures to address needs of the residents with Alcohol and Drug abuse problems and Management of Residents with a History of Substance abuse. -The facility Educated 95% of the facility staff on the newly developed policies and procedures and on identification of care for residents' with a history of using Polysubstance/Polydrug abuse and identifying signs and symptoms of drug abuse. The facility also educated staff on narcotic overdose and use of Narcan. The staff that did not receive in-service education were either on vacation, on medical leave, or not were been scheduled for duty and will be in-serviced as they report to work. - The facility assessed and formulated care plans for all residents identified as having a history of Polysubstance abuse. -The facility created Resident contracts/agreements to educate residents on the facility's zero tolerance drug policy along with consequences. -The facility developed audit tools to monitor residents with a history of Substance abuse for signs and symptoms of drug abuse and updated the room search audit tool to include legal and illegal substances.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observation, interviews and record review during the Recertification Survey initiated on 3/1/2022 and completed on 3/9/2022, the facility failed to ensure each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This was identified for one (Resident #220) of three residents reviewed for Behavioral health. Specifically, Resident #220 was admitted to the facility with a known history of illicit drug abuse. The admission psychosocial assessment dated [DATE] documented the resident was utilizing and selling illicit drugs in the previous nursing facility. The facility failed to develop and implement an effective comprehensive person-centered plan of care to address the substance abuse disorder. On 12/13/2021, Resident #220 was found unresponsive, was transferred to the hospital, and was diagnosed with an overdose from opiate use. No assessments or changes to the resident's plan of care were made upon their return from the hospital on 12/16/2021. Subsequently, Resident #220 was again found unresponsive on 3/2/2022, was transferred to the hospital for an overdose of Heroin and was diagnosed with Acute Hypercapnic Respiratory failure secondary to unintentional overdose. This resulted in actual harm to Resident #220 with potential for serious harm for 64 residents with a history of drug abuse that is Immediate Jeopardy. The finding is: The facility policy on assessment process dated 12/2021 documented that all residents receive timely, accurate, and appropriate interdisciplinary assessment and care planning. The assessment and review should be completed upon return from the hospital, when there is a significant change that appears to be permanent, based on a comparison of the resident's pre and post hospital status. The facility Behavior Documentation Policy and Procedure dated 4/4/2008 and last revised in 3/2022 documented to monitor residents' behavior and document on a daily basis. Behavior documentation is done on a daily basis on the Certified Nursing Assistant (CNA) Accountability Record by the CNA. It is the responsibility of the caregiver to document the resident's behavior, the intervention utilized for that behavior, and the efficacy of the intervention used every shift. The facility Contraband policy and procedure dated 11/2021 documented in order to ensure a safe environment, all residents presenting to the facility will be subject to a search directed towards identifying contraband and preventing its entrance into the facility. The policy defined contraband as items of danger including illegal substances. The procedure documented that all residents who enter the facility will be subjected to search if any suspected, or any evidence of having contraband. If a resident is found to have controlled substances during their stay, the staff member who finds the controlled substances will bring this to the attention of the attending in charge and the nurse in charge. Visitors who bring contraband into the facility may be asked to leave and may be denied visiting privileges in the future. The resident involved may become subject to a repeat search with confiscation or checking of objects as described above. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility did not have a documented Policy and Procedure for management of residents with diagnosis of Substance Abuse. Resident #220 was admitted with diagnoses of Polysubstance Abuse, Anxiety Disorder, Depression and status post Laminectomy. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #220 required limited assistance of one-person with locomotion in the resident's room. The locomotion off the unit did not occur in seven days of the MDS look back period. The MDS documented the resident was feeling depressed, or hopeless, and had disturbed sleep. The Quarterly MDS assessment dated [DATE] documented Resident #220 had a BIMS score of 15, indicating intact cognition. The MDS further documented Resident #220 required supervision without physical help from staff for locomotion on and off the unit. The resident was feeling depressed, or hopeless, and had disturbed sleep. The resident exhibited behavioral symptoms that were not directed towards others in four to six days in the last 7 day look back period of the MDS. Resident #220 was observed on 3/1/2022 at 10:29 AM seated in their wheelchair in the hallway and conversing with another resident. Resident #220 stated that there are no activities that meet their interests. Resident #220 stated that it was very boring at the facility, and they (Resident #220) had complained to the recreation staff. Resident #220 stated that nothing was done and they did not find the current activities appropriate for them (Resident #220). The psychosocial assessment dated [DATE] documented Resident #220 was at another skilled nursing facility for 2 years for back issues. Resident was discharged in August 2021 from the other facility. Resident #220 was admitted to the current facility on 8/24/2021 for subacute rehabilitation and was discharged on [DATE]. Resident #220 decided they (Resident #220) could not stay where they were discharged to and had several hospitalization s until admitted as a second admission to the facility on [DATE]. The psychosocial assessment documented Resident #220 was kicked out of previous facility for using and selling heroin, fentanyl, and cocaine. The psychosocial assessment documented that Resident #220's judgement was poor. Resident #220 was noted to be anxious, impulsive, easily agitated, and disregarded rules. The history of polysubstance abuse care plan dated 9/28/2021 documented that Resident #220 was kicked out of a previous skilled nursing facility for using and selling heroin, fentanyl and cocaine. Resident #220 knew what was done was wrong and will not do that in the current facility. The goal included that Resident #220 will not use or sell illegal substances. The interventions included to encourage participation in activities of interest, social work one to one visits for emotional support and counselling as needed, psychiatric consultation, and psychological services follow up as needed. There were no care plan updates from 9/21/2021 to 3/2/2022. The psychology consultation dated 10/14/2021 documented that Resident #220 had diagnoses of Anxiety, Depression, and Substance Abuse. Resident #220 reported briefly receiving psychotherapy at a previous Skilled Nursing Facility. Resident #220 reported that they (Resident #220) were living with a friend but were unhappy with the arrangement because their friend was using drugs. The Psychologist documented the Resident #220 presents with a history of drug abuse and was homeless with limited social supports and significant health issues. Resident #220 agreed to speak with the Psychologist today but declined psychotherapy and was coping adequately. No psychotherapy was recommended at this time. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Physician's Order dated 12/2/2021 documented to obtain a psychological evaluation for Anger Management due to Resident #220 having a peer-to-peer altercation. There was no documented evidence that a psychological evaluation was completed after the 12/2/2021 referral. The Situation Background Assessment Recommendation (SBAR) Communication Form dated 12/13/2021 documented Resident #220 had a change in condition with symptoms of altered mental status. The SBAR documented Resident #220 presented with altered level of consciousness, weakness, and shortness of breath. Around 9:00 PM, Resident #220 was observed sitting in the chair very lethargic with alteration in consciousness and was transferred to the hospital. The hospital record dated 12/13/2021 documented that Resident #220 was admitted to the hospital for altered mental status with Acute Hypoxic Respiratory Failure secondary to drug overdose (cocaine, opiate and benzodiazepine) with moderate improvement after Narcan 2 milligram (mg) injection. As per Emergency Medical Service (EMS) the oxygen saturation rate for Resident #220 was 82% (normal 95% or above) on room air at the Skilled Nursing Facility and was Hypotensive (low blood pressure). The hospital discharge summary dated 12/15/2021 documented a note to the Skilled Nursing Facility: supervised visiting only. Resident #220 has been receiving drugs from outside visitors and subsequently overdosed. There was no documented evidence of an investigation to determine the root cause of Resident #220's opiate overdose nor where and how the resident received the drugs. The Nursing Admission/Readmission note dated 12/16/21 documented that Resident #220 was admitted from the hospital at 7:40PM. Resident to only have supervised visitation. The Social Work note dated 12/16/2021 documented Resident #220 stated that a visitor brought the drugs to the building. Resident #220 stated that they took the visitor's phone number out of their phone and will not do it again. The Social Worker re-educated Resident #220 about not to smoke or vape in the facility. A document titled Resident Delivery Searches dated 12/2021 documented that when a delivery comes to the facility for any of the following residents, the deliveries are to be searched for contraband. The list of names included Resident #220. The Physician readmission note dated 12/17/2021 documented Resident #220 had a past medical history of Polysubstance Abuse. Resident #220 was admitted on [DATE] [to the hospital] for altered mental status with Acute Hypoxic Respiratory Failure secondary to drug overdose (cocaine, opiate and benzodiazepine) with moderate improvement after Narcan 2mg injection. The assessment and plan included to continue current medications, provide safe environment, adequate nutrition, and supportive care. Monitor fingerstick, GI follow up for hepatic mass and psychiatry follow up. The Physician did not acknowledge the recommendation from the hospital related to supervised visitation for Resident #220. The Physician's Order dated 12/28/2021, 11 days after the Physician's readmission note, documented to obtain a Psychiatric consultation for adjustment disorder. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Social Work note dated 1/4/2022 documented Resident #220 was moving from Unit 22 to Unit 46. Resident #220 was educated about not smoking or vaping in the facility. The Physician's note dated 1/12/2022 documented that Resident #220 has not had any acute events. The assessment and plan included to provide current medications, provide safe environment, adequate nutrition, and supportive care. The Physician did not acknowledge the recommendation from the hospital related to supervised visitation for Resident #220. The Psychiatric Evaluation dated 1/28/2022, one month after requested by the Physician, documented Resident #220 had the diagnoses of Insomnia, Anxiety Disorder and Depression. The social history included a history of polysubstance abuse. The recommendation included to decrease Xanax to 0.5 mg from 1mg and individual therapy 2-5 times monthly. There was no documented evidence that the individual therapy 2-5 times monthly was offered or provided to Resident #220. The physician's note dated 2/9/2022 documented that Resident #220 has not had any acute events and Resident #220 was able to transfer out of bed to ambulate by pushing the wheelchair independently. The physician documented that Resident #220 has a history of anxiety that is controlled with Xanax. Psychiatry recommended to decrease Xanax and Resident #220 gets very agitated and violent when you try to discuss tapering the Xanax. Resident #220 is on Cymbalta, Oxycodone and Baclofen for chronic back pain. Will decrease Cymbalta and discontinue Baclofen and follow up Psychiatry regularly. The assessment and plan included to provide current medications, provide safe environment, adequate nutrition, and supportive care. The facility did not provide evidence of a Psychiatric follow up after 1/28/2022. Nursing progress notes from 2/1/2022 to 3/2/2022 were reviewed. There was no documented evidence that the resident was being monitored or supervised for drug seeking behavior, attempts to sell illicit drugs, or consumption of illicit drugs prior to 3/2/2022. The December 2021 to March 2022 Certified Nursing Assistant (CNA) Accountability Records documented Resident #220 had a diagnosis of Polysubstance abuse. The CNA Accountability Records documented that Resident #220 could push the wheelchair independently. There was no documented evidence that the resident was to have supervision or monitoring related to Polysubstance abuse. The SBAR Communication Form dated 3/2/2022 documented Resident #220 had a change in condition. At 6:00 PM, Resident #220 was unresponsive to verbal and tactile stimuli. The SBAR documented oxygen saturation level of 66% when on oxygen at 3 liters per minute. Resident #220 was transferred to the hospital. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The hospital record dated 3/2/2022 documented Resident #220 was transferred from the Skilled Nursing Facility for altered mental status. Resident #220 was brought in by EMS from the Skilled Nursing Facility for possible overdose. Narcan 2mg was administered intramuscularly by EMS. Resident #220 stated that they (Resident #220) snorted some Heroin and passed out. Resident #220 had an admission three months ago in December [2021] for a similar overdose. Resident #220 was admitted to the hospital for altered mental status secondary to opioid intoxication. The urine toxicology report was positive for opiates and benzodiazepines. The attending physician at the hospital diagnosed Resident #220 with toxic encephalopathy secondary to opioid intoxication and Substance abuse. Certified Nursing Assistant (CNA) #8 was interviewed on 3/03/2022 at 2:17 PM and stated they (CNA #8) were the regularly assigned CNA for the 7AM to 3PM shift for Resident #220 for the past 2 months. Resident #220 did not have any specific instructions to be monitored. CNA #8 stated that Resident #220 was independent in mobility and did not require any oversight. CNA #8 stated that they have not received any instructions to look through Resident #220's belongings to check for substance abuse related materials. CNA #8 was not aware if Resident #220 had any visitors on 3/2/2022 or even in the past month. CNA #8 further stated that there were no special instructions to monitor Resident #220 for substance abuse behaviors and there was no direction provided to supervise the resident throughout the facility. Registered Nurse (RN #7) was interviewed on 3/3/2022 at 2:20 PM. RN #7 stated that they (RN #7) were the regular 7AM to 3PM shift Unit Nurse for Resident #220's unit and has known Resident #220 since the resident was transferred to the unit two months ago. RN #7 stated that the staff did not have any specific instructions for monitoring Resident #220's whereabouts in the facility or for supervised visits. RN #7 was not aware if Resident #220 had any visits on 3/2/2022. RN #7 stated that they were aware of Resident #220's history of substance abuse but thought it was a long time ago. RN #7 was not aware of Resident #220's overdose in the facility in December 2021. RN #7 did not receive any instructions to look through Resident #220's belongings to check for substance abuse related materials. CNA #9 was interviewed on 3/3/2022 at 3:15 PM and stated that they (CNA #9) were the assigned CNA for Resident #220 on the 3PM -11PM nursing shift on 3/2/2022. CNA #9 stated that they did not have any instructions for monitoring the resident for substance abuse behaviors and were not aware of Resident #220's history of drug overdose at the facility. CNA #10 was interviewed on 3/3/22 at 3:20 PM and stated that they (CNA #10) were the regularly assigned CNA on the 11:00 PM to 7:00 AM nursing shift for the past 2 months for Resident #220. CNA #10 stated they rarely went into Resident #220's room because Resident #220 was able to care for themself. CNA #10 stated that there was nothing on the CNA accountability record that instructed the CNAs to monitor the resident for drug abuse behavior. CNA #10 further stated they (CNA #10) were not aware of Resident #220's overdose and illicit drug use in the facility. RN #10 was interviewed on 3/3/2022 at 3:26 PM and stated that they (RN #10) were the RN Supervisor on 3/2/2022 on the 11 PM-7AM nursing shift and was covering the 3 PM-11 PM nursing shift on Resident #220's unit. RN #10 stated that they were called by RN #8 to Resident #220's room because Resident #220 presented with an altered mental status and was not waking up. Resident #220's oxygen saturation level was 66%. RN #10 was aware of Resident #220's overdose in December 2021 but did not suspect that the resident had a drug overdose in this case. RN #10 did not tell the EMS anything about Resident #220's drug abuse behavior. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN #8 was interviewed on 3/3/2022 at 3:52 PM and stated that they (RN #8) were covering the 3PM-11PM nursing shift on 3/2/2022. RN #8 stated they were not the regularly assigned nurse for the resident's unit. At 5:00PM, RN #8 went to Resident #220's room and Resident #220 seemed out of it. Resident #220 was transferred to the hospital due to the unresponsiveness. RN #8 stated they (RN #8) were not aware that Resident #220 had substance abuse behaviors and had overdosed in December 2021 in the facility. RN #8 further stated that there were no Physician's orders or instructions related to substance abuse monitoring for Resident #220. Social Worker (SW) #2 was interviewed on 3/3/2022 at 5:11 PM and stated Resident #220 had a short stay at the facility from 8/24/2021 to 9/3/2021 and was readmitted on [DATE] which was considered a new stay. SW#2 stated that Resident #220 informed them (SW #2) that Resident #220 was kicked out of another skilled nursing facility two years ago because of selling and using illicit drugs. Resident #220 informed SW #2 that they (Resident #220) were clean and were not using illicit drugs when they were admitted on [DATE]. Resident #220 was referred to psychology for therapy and only had one psychotherapy session in October 2021. SW #2 stated that the plan of care for history of substance abuse was to refer Resident #220 to psychology and to check any incoming packages for illicit drugs. SW #2 stated that searching packages is a standard protocol in the facility and did not have to be in a care plan. The nursing staff are expected to look through food items brought in from outside as per the facility-wide protocol. SW #2 stated that Resident #220 was not actively having substance abuse disorder so a care plan to prevent and monitor substance abuse behavior was not developed. SW #2 stated that Resident #220 had a history of smoking in their room and it is the facility's protocol to search the room only when they suspect smoking. SW #2 stated that the facility cannot always search Resident #220's belongings and there is only so much we can do. On 12/13/21, Resident #220 was found in their room unresponsive and was hospitalized . SW #2 stated that they (SW #2) followed up with Resident #220 on 12/16/21 and educated Resident #220 on the facility rules. SW #2 stated that Resident #220 was placed on SW #1's caseload when readmitted on [DATE]. SW #2 stated that it was SW #1's responsibility to develop and update the care plan to address Resident #220's substance abuse behavior when Resident #220 was readmitted on [DATE]. SW #1 was interviewed on 3/3/22 at 5:51 PM. SW #1 stated that they were assigned to Resident #220 upon their readmission in December 2021 after the resident returned from the hospital from the opiate overdose. SW #1 stated that they did not complete a psychosocial assessment and did not develop a revised plan of care to address Resident #220's substance abuse behavior. SW #1 stated that they could not recall reviewing the hospital discharge paperwork with the instruction for supervised visitation to reduce substance abuse behavior. SW #1 stated that an interdisciplinary team approach was not used to address Resident #220's substance abuse behavior. SW #1 stated that they did not initiate any additional interventions for Resident #220 after the resident's return from the hospital on 12/16/2021. Resident #220 was reassigned to SW #2 on 1/4/2022. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Medical Director and Director of Nursing was interviewed concurrently on 3/3/22 at 6:30 PM. The Medical Director stated that Resident #220's diagnosis of Policy Substance Abuse is noted on the medical record and the staff are aware of Resident #220's history. The Director of Nursing stated that everyone on the team is aware of Resident #220's substance abuse history is noted in the medical record. The Director of Nursing stated that the facility did not initiate an Incident Report to investigate how Resident #220 obtained drugs in the facility on 12/13/2021 because SW #2 had written a note that Resident #220 received the drugs from a visitor. The Director of Nursing stated that the facility was in COVID-19 quarantine and Resident #220 did not require increased supervision. The Director of Nursing stated that the visitation protocols were facility wide and did not need to be documented in a care plan. The Director of Nursing stated that Resident #220 refused psychotherapy in the past. The Medical Director stated that they were not aware if the psychotherapist had seen Resident #220 after 12/16/2021. The Medical Director was not aware if the substance abuse behaviors were addressed in psychotherapy or psychiatry and if substance abuse treatment was offered. The Director of Nursing stated that it was the hospital's responsibility to refer Resident #220 to a drug rehabilitation programs and that the facility can only offer psychiatric and psychological care. The Director of Recreation was interviewed on 3/4/22 at 2:40 PM. The Director of Recreation stated that Resident #220 preferred extra newspapers and enjoyed watching television. The Director of Recreation stated that during the outbreak in December 2021 and January 2022, activities were provided one to one or in the room. When Resident #220's unit was cleared in February 2022, Resident #220 would go out to the courtyard when weather permitted and self-propelled throughout the facility, to other units to talk to other residents and to go to the vending machines. Attending Physician #2 was interviewed on 3/4/22 at 3:42 PM and stated that they (Attending Physician #2) provided care for Resident #220 since Resident #220 was moved to Unit 46 on 1/4/2022. Resident #220 has a history of high blood pressure, chronic lower back pain, and anxiety disorder. Attending Physician #2 stated that Resident #220 was known to have agitated and aggressive behaviors and was followed by a psychiatrist. Resident #220 refused psychotherapy on several occasions. Attending Physician #2 stated that they (Attending Physician #2) believed that Resident #220 was very agitated when the suggestion to decrease the Xanax was recommended by the psychiatrist and Attending Physician #2 reduced Cymbalta instead. Attending Physician #2 stated that Resident #220 required monitoring and supervision and they (Attending Physician #2) had verbally informed CNA #10 and RN #7 to monitor Resident #220 for Substance abuse behavior. Attending Physician #2 stated that they did not recall documenting the need for increased monitoring for substance abuse behaviors or placing an order instructing nurses to do so. SW #2 was re-interviewed on 3/4/2022 at 5:15 PM. SW #2 stated that the facility staff located Resident #220's care plan entitled history of substance abuse which was dated 9/28/2021. The interventions did not include to monitor and supervise Resident #220's whereabouts in the facility for substance abuse behavior. SW #2 stated that they had developed the care plan but did not revise the care plan after the resident returned from the hospital on 12/16/2021 since that was the responsibility of SW #1. Resident #220 should have had a revised care plan after the 12/13/2021 hospitalization . The care plan did not include any updates in December 2021. Resident #220 was not on the radar for active use of drugs at the time of the 9/28/2021 care plan. The search of packages is a standard practice for any resident in the facility so that intervention would not be in the care plan. The facility was notified of the Immediate Jeopardy on 3/3/2022. The Immediate Jeopardy was removed on 3/7/2022 prior to the completion of the survey. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The facility created policies and procedures to address needs of the residents with Alcohol and Drug problems and Management of Residents with History of Substance abuse. -The facility Educated 95% of the facility staff on the newly developed policies and procedures and on identification of care for resident history of using Polysubstance/Polydrug abuse and identifying signs and symptoms of drug abuse. The facility also educated staff on narcotic overdose and use of Narcan. Those not in-serviced are either on vacation, on medical leave, or have not been scheduled for duty and will be in-serviced as they report to work. - The facility assessed and formulated care plans for all residents identified as having history of Polysubstance abuse. -The facility created Resident contracts/agreements to educate residents on facility's zero tolerance drug policy along with consequences. -The facility developed audit tools to monitor residents with history of Substance abuse history for signs and symptoms of drug abuse and updated the room search audit tool to include legal and illegal substances.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review and staff interviews during the Recertification Survey initiated on 3/1/2022 and completed on 3/9/2022, the facility did not ensure that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This was identified on one of thirteen units reviewed for the Medication Storage task. Specifically, Resident #364 was administered Alprazolam (psychotropic) 0.5 milligrams (mg) without accurate reconciliation on the Control Substance Administration Record (Narcotic Sheet). The finding is: The facility's undated Medication Administration Policy and Procedure documented upon removal of the controlled substance from the container the nurse must record the date, hour, amount used, signiture and the amount of the controlled substance remaining on the Controlled Substances Administration Record form. The nurse. The Policy further documented the nurse administer the medication per the policy then documents the date and time on the Medication Administration Record. Resident #364 was admitted with diagnoses that include Anxiety disorder and Depression. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. The MDS documented the resident received Antianxiety medication for the seven days during the assessment look back period. During a Medication Storage observation on 3/7/2022 at 12:05 PM on nursing unit 31, the unit medication cart was observed, including the Narcotic medications in the cart. Resident #364's Controlled Substance Administration Record for Alprazolam was reviewed. The Controlled Substance Administration Record documented that the last Alprazolam tablet was administered on 3/6/2022 at 8:00 PM. The amount of the Alprazolam medication remaining on the Controlled Substance Administration Record was documented to be 22 tablets. However, the Alprazolam medication tablets remaining in the blister pack were 21 tablets. The Medication Administration Record (MAR) beginning dated 2/16/2022 was reviewed and revealed the Alprazolam was not signed as administered on 3/7/22 at 8:00 AM. The Licensed Practical Nurse (LPN) #3 was interviewed on 3/7/22 at 12:15 PM and stated they (LPN #3) had administered the medication to Resident #364 at 8:00 AM on 3/7/22 but did not sign the Controlled Substance Administration Record. LPN #3 stated when they (LPN #3) removed the tablet from the blister pack, they (LPN #3) should have signed the Control Substance Administration Record and after administering the medication they should have signed the MAR. The Registered Nurse (RN) #6, who was the Nurse Manager, was interviewed on 3/7/22 at 12:20 PM and stated that all the nurses are instructed to sign the Narcotic Sheet after removing the narcotic medication from the blister pack. RN #6 stated that LPN #3 should have signed the Controlled Substance Administration Record at the time the tablet was removed from the blister pack and should have signed the MAR after administering the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services (DNS) was interviewed on 3/9/2022 at 1:23 PM and stated when LPN#3 removed the medication from the blister pack LPN #3 should have signed the Control Substance Administration Record right away. After administering the medication to the resident, LPN #3 should have signed the MAR. 415.18(b)(1)(2)(3)