STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Valley Center for Nursing and Rehabilitation	1000 College Street Wilkesboro, NC 28697

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record reviews, staff and Nurse Practitioner interviews the facility failed to notify the physician of medication unavailability for 3 of 3 residents (Resident #2, Resident #3 and Resident #4) reviewed for medications. The findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included hyperlipidemia, restless leg syndrome, chronic obstructive pulmonary disease, hypertension, atrial fibrillation, pain, gastrointestinal reflux disease, diabetes mellitus and nondisplaced fracture of right femur. Resident # 2 was admitted on [DATE] with physician orders for the following medications: -Gabapentin (used for treatment of nerve pain) 600 (mg) milligrams one tablet by mouth at bedtime for pain management, available in Cubex, (a tower of medications available for the staff to pull medications from until the residents' medications arrive from the pharmacy) -Pravastatin Sodium (used for treatment of high cholesterol) 10 mg tablet by mouth at bedtime for hyperlipidemia, not in Cubex -Tizanidine HCL (a muscle relaxant) 4 mg tablet by mouth at bedtime for muscle spasms, not in Cubex -Brovana Nebulization Solution (a bronchodilator used to treat breathing problems) inhale 2 (ml) milliliters orally via nebulizer two times a day for chronic obstructive pulmonary disease, not in Cubex -Budesonide Suspension Solution (a steroid used to help prevent symptoms of asthma) inhale 2 ml orally via nebulizer two times a day for chronic obstructive pulmonary disease, not in Cubex -Carvedilol (used to treat high blood pressure) 25 mg tablet by mouth two times a day for hypertension, in Cubex -Eliquis (a blood thinner) 5 mg tablet by mouth two times a day for atrial fibrillation, in Cubex (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hydrocodone-Acetaminophen (an analgesic used to treat pain) 10-325 mg tablet by mouth two times a day for pain, in Cubex -Protonix Delayed Release (used to treat high levels of stomach acid) 40 mg capsule by mouth two times a day for gastrointestinal reflux disease, in Cubex A review of Resident #2's Medication Administration Record (MAR) for 06/2022 revealed the Resident's medications scheduled to be given at 8:00 PM on the day of admission 06/09/22 were documented as #9 which indicated not given by Nurse #3. The MAR further revealed that at 8:00 AM on 06/10/22 the Brovana and Budesonide nebulizing treatments were documented as #5 which indicated Hold by the Wound Care Nurse. A review of Resident #2's medical record revealed there was no documentation that the physician was notified of medication unavailability on 06/09/22 or 06/10/22. On 08/18/22 at 2:35 PM during an interview with the Wound Care Nurse she confirmed she worked on 06/10/22 for the 8:00 AM medication pass and did not give Resident #2 his medications. The Wound Care Nurse explained that day was the first day she was pulled to the medication cart and had never had orientation to the medication system. She stated she was supposed to be trained by the previous Director of Nursing (DON), but the DON was not available when she needed her counsel on issues. One of the issues were the breathing treatments for Resident #2, she could not find them, so she documented in the nurses' notes to hold per nurses' judgement. The Wound Care Nurse explained that she now understood that she should have looked in the Cubex, (a tower of medications available for the staff to pull medications from until the residents' medications arrive from the pharmacy) for the medication and if not available she should have notified the physician for a substitute or further direction but she didn't know that at the time of the incident. The Wound Care Nurse stated she did not have access to the Cubex. On 08/19/22 at 8:45 AM an interview was conducted with Nurse #3 who confirmed she worked the 7:00 PM to 7:00 AM shift on 06/09/22. The Nurse explained that Resident #2 arrived at the facility that evening shortly before her shift, but she did not give the 8:00 PM scheduled medications to Resident #2. She continued to explain that she had access to the Cubex that she could have pulled the medications from if the medications were in the Cubex but she figured that since the medications were not antibiotics then it would not hurt to wait for the Resident's medications to be delivered from the Pharmacy's next routine delivery which would be in the early morning hours. The Nurse continued to explain that she was trained to obtain the ordered medications from the Cubex if available and if not then she should have contacted the physician for a substitute or further directions but she did not do that and added she must have been busy that night. On 08/19/22 at 3:00 PM during an interview with the Nurse Practitioner (NP) she explained that the nurses should have obtained the medications from the Cubex and if the ordered medications were not available in the Cubex then the nurses should have called her or the physician for further instructions. She continued to explain that she had requested that more nurses have access to the Cubex because it could be a scramble to find a nurse that had access to the Cubex especially for there to be two nurses on duty that has access which was what was needed in order to remove narcotics from the Cubex. The NP stated she did not recall receiving a phone call about not having Resident #2's medications available. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #2 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included hyperlipidemia, deep vein thrombosis, anxiety, hypertension, post traumatic stress syndrome. Resident #3 was admitted on [DATE] with physician orders for the following medications: -Atorvastatin Calcium (used to treat high cholesterol)80 mg tablet by mouth at bedtime for hyperlipidemia, in Cubex -Plavix (a blood thinner) 75 mg tablet by mouth at bedtime for deep vein thrombosis, in Cubex -Diazepam (used to treat anxiety) 5 mg tablet give 0.5 tablet by mouth at bedtime for anxiety, not in Cubex -Cardura (used to treat high blood pressure) 1 mg tablet by mouth at bedtime for hypertension, not in Cubex -Minipress (used to treat high blood pressure) 1 mg capsule by mouth at bedtime for hypertension, not in Cubex -Eliquis (a blood thinner) 5 mg tablet by mouth two times a day for deep vein thrombosis, in Cubex -Oxcarbazepine (can be used as a mood stabilizer) 150 mg tablet by mouth two times a day for post traumatic stress syndrome, not in Cubex A review of Resident #3's Medication Administration Record (MAR) for 08/2022 revealed the Resident's medications scheduled to be given at 9:00 PM on the day of admission 08/05/22 by Nurse #1 but were documented as #9 which indicated not given. A review of Resident #3's medical record revealed there was no documentation of the Provider being notified of unavailability of medications on 08/05/22. An interview was conducted with Nurse #1 on 08/18/22 at 10:05 AM. The Nurse confirmed she worked on 08/05/22 and admitted Resident #3 from the hospital to the facility that afternoon. The Nurse explained that she documented the medications as HOLD, not given because the medications had not yet arrived from the Pharmacy and she did not have access to the Cubex. She continued to explain that she would have called the physician and asked for substitutes and she would have documented that she called in the medical record. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/19/22 at 3:00 PM during an interview with the Nurse Practitioner (NP) she explained that the nurses should have obtained the medications from the Cubex and if the ordered medications were not available in the Cubex then the nurses should have called her or the physician for further instructions. She continued to explain that she had requested that more nurses have access to the Cubex because it could be a scramble to find a nurse that had access to the Cubex especially for there to be two nurses on duty that has access which was what was needed in order to remove narcotics from the Cubex. The NP stated she did not recall receiving a phone call about not having Resident #2's medications available. During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #3 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medications not given through the computer system used by the facility and checked the documentation every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. 3. Resident #4 was admitted to the facility on [DATE] with diagnoses that included hypertension and deep vein thrombosis. Resident #4 was admitted on [DATE] with physician orders for the following medications: -Xarelto (a blood thinner) 20 mg tablet by mouth one time a day for deep vein thrombosis, in Cubex -Potassium Chloride ER (used for low potassium) 20 (meq) milliequivalent tablet by mouth two times a day for hypokalemia, in Cubex A review of Resident #4's Medication Administration Record (MAR) for 08/2022 revealed the Resident's medications scheduled to be given at 6:00 PM on the day of admission 08/11/22 were documented as #9 which indicated not given by Nurse #1. A review of Resident #4's medical record revealed there was no documentation of the Provider being notified of medication unavailability on 08/11/22. An interview was conducted with Nurse #1 on 08/18/22 at 10:05 AM. The Nurse confirmed she worked on 08/11/22 and admitted Resident #4 to the facility. The Nurse explained that she documented the medications as HOLD, not given because the medications had not yet arrived from the Pharmacy and she did not have access to the Cubex. The Nurse stated she was an agency nurse and the facility did not allow the agency staff to have access to the Cubex. She continued to explain that she was recently educated to call the physician if the medications were not given within a two-hour time frame but stated she did not do it. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/19/22 at 3:00 PM during an interview with the Nurse Practitioner (NP) she explained that the nurses should have obtained the medications from the Cubex and if the ordered medications were not available in the Cubex then the nurses should have called her or the physician for further instructions. She continued to explain that she had requested that more nurses have access to the Cubex because it could be a scramble to find a nurse that had access to the Cubex especially for there to be two nurses on duty that has access which was what was needed in order to remove narcotics from the Cubex. The NP stated she did not recall receiving a phone call about not having Resident #2's medications available. During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #4 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medication documentation through the computer system they used and had been able to follow up with the nurses more promptly. The DON stated she needed to be more diligent in monitoring the records every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record reviews, staff and Resident interviews the facility failed to provide written responses to resolutions of four grievances for 1 of 1 resident (Resident #5) reviewed for grievances. The findings included: A review of the facility's Grievance Policy dated 11/01/20 indicated the philosophy of care for all residents admitted to the facility is Doing the right things, for the right reasons. The commitment applied to the receipt, resolution and response to resident grievances or concerns. The policy stated the resident will be provided a written summary of the resolution of the grievance. Resident #5 was admitted to the facility on [DATE]. The annual Minimum Data Set assessment dated [DATE] indicated Resident #5 was cognitively intact. An interview was conducted with Resident #5 on 08/17/22 at 2:30 PM. The Resident voiced concern that she did not receive written documentation of the resolution to her grievances. A review of the grievance log revealed Resident #5 filed grievances on 07/02/22, 07/08/22, 07/11/22 and 07/18/22. All the grievances indicated they were resolved by the Director of Nursing and the Resident was given verbal notification of the resolution to the grievances. An interview was conducted with the Director of Nursing (DON) on 08/18/22 at 6:00 PM. The DON confirmed she investigated the grievances filed by Resident #5 and explained that she always reviewed the grievances with Resident #5 and obtained verbal confirmation of resolution. The DON stated she was not aware that the facility needed to provide the person filing the grievance a written summary of the resolution. During an interview with the Administrator on 08/19/22 at 4:30 PM the Administrator explained that she was aware that the facility had not been providing the person who filed the grievance a written summary of resolution as indicated in the facility's Grievance policy and would immediately implement the procedure.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record reviews and staff interviews the facility failed to report upon notification of an allegation of neglect to the State Agency within the timeframes of 24 hours for the Initial Report and 5 days for the Investigation Report for one of one resident reviewed for neglect (Resident #2). The finding included: A review of a facility reported incident (FRI) of a 5-Working Day Report dated 06/24/22 at 5:28 PM indicated the Initial Report of 24 hours was faxed to the state agency on 06/15/22 via fax. The report revealed Resident #2 was admitted to the facility on [DATE] with no order for a CPAP (continuous positive airway pressure) machine and the Resident's medications were delayed but given. The Resident's condition worsened and was sent out to the emergency roiagnom on [DATE] around midnight. The Resident's daughter called the facility on 06/13/22 at 12:00 PM accusing the facility of alleged neglect. The report indicated Nurse #3 was suspended pending outcome of the investigation. The allegation of neglect was determined to be unsubstantiated. On 08/18/22 at 10:50 AM an interview was conducted with the Administrator #2 who explained that the alleged allegation occurred prior to her employment with the facility and that she heard about the allegation through a staff member but could not remember who the staff member was. The Administrator continued to explain that she discovered the allegation had not been reported to the State, so she decided it needed to be reported and confirmed that was why the reports were submitted late. The Administrator stated she faxed the Initial 24 Hour Report (on 06/15/22) separately from the 5 day Investigation Report which she faxed on 06/24/22. The Administrator explained that she suspended Nurse #3 pending the outcome of the investigation. She explained that she discovered that the Resident's medications were given but were given late and that the Resident's family had brought his CPAP machine to the facility from home the day of his admission, so the facility obtained an order for the CPAP. The Administrator stated the allegation of neglect was unsubstantiated. An interview was conducted with the Regional [NAME] President of Operations (RVPO) on 08/18/22 at 5:45 PM who confirmed that both the Initial 24 Hour Report and the 5 Day Investigation Report was reported late to the State Agency and explained the Administrator was educated on the regulation of reporting alleged neglect allegations timely.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record reviews and staff, Nurse Practitioner and Pharmacist interviews the facility failed to administer physician ordered medications for 3 of 3 residents (Resident #2, Resident #3 and Resident #4) reviewed for medications. The findings include: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included hyperlipidemia and gastrointestinal reflux disease. Resident #2 was admitted on [DATE] with physician orders for the following medications: -Pravastatin Sodium (given to lower cholesterol) 10 mg tablet by mouth at bedtime for hyperlipidemia, not in Cubex -Protonix Delayed Release (lowers gastric acid) 40 mg capsule by mouth two times a day for gastrointestinal reflux disease, in Cubex A review of Resident #2's Medication Administration Record (MAR) for 06/2022 revealed the Resident's medications scheduled to be given at 8:00 PM on the day of admission 06/09/22 were documented as #9 which indicated not given by Nurse #3. A review of Resident #2's medical record revealed there was no documentation that the physician was notified of medication unavailability on 06/09/22. On 08/19/22 at 8:45 AM an interview was conducted with Nurse #3 who confirmed she worked the 7:00 PM to 7:00 AM shift on 06/09/22 and did not give the 8:00 PM scheduled medications to Resident #2. The Nurse explained that she had access to the Cubex that she could have pulled the medications from if the medications were in the Cubex but she figured that since the medications were not antibiotics then it would not hurt to wait for the Resident's medications to be delivered from the Pharmacy which would be in the early morning hours. The Nurse continued to explain that she was trained to obtained the ordered medications from the Cubex if available and if not then she should have contacted the physician for a substitute or further directions but she did not do that and added she must have been busy that night. On 08/19/22 at 3:00 PM during an interview with the Nurse Practitioner (NP) she explained that the nurses should have obtained the medications from the Cubex and if the ordered medications were not available in the Cubex then the nurses should have called her or the Provider for further instructions. The NP stated she did not recall receiving a phone call about not having Resident #4's medications available. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uring an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #2 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist reviewed Resident #2's medication regimen and explained that missing one or two doses of his medications was not a detriment to his condition because most of the medications were long lasting. The Pharmacist continued to explain that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included hyperlipidemia and deep vein thrombosis. Resident #3 was admitted on [DATE] with physician orders for the following medications: -Atorvastatin Calcium (lowers cholesterol) 80 mg tablet by mouth at bedtime for hyperlipidemia, in Cubex -Plavix (a blood thinner) 75 mg tablet by mouth at bedtime for deep vein thrombosis, in Cubex A review of Resident #3's Medication Administration Record (MAR) for 08/2022 revealed the Resident's medications scheduled to be given at 9:00 PM on the day of admission 08/05/22 by Nurse #1 but were documented as #9 which indicated not given. A review of Resident #3's medical record revealed there was no documentation of the physician being notified of unavailability of medications on 08/05/22. An interview was conducted with Nurse #1 on 08/18/22 at 10:05 AM. The Nurse confirmed she worked on 08/05/22 and admitted Resident #3 to the facility. The Nurse explained that she documented the medications as HOLD, not given because the medications had not yet arrived from the Pharmacy and she did not have access to the Cubex. She continued to explain that she would have called the physician and asked for substitutes and she would have documented it in the Resident's medical record. On 08/19/22 at 3:00 PM during an interview with the Nurse Practitioner (NP) she explained that the nurses should have obtained the medications from the Cubex and if the ordered medications were not available in the Cubex then the nurses should have called her or the physician for further instructions. The NP stated she did not recall receiving a phone call about not having Resident #4's medications available. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #3 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medications not given through the computer system used by the facility and checked the documentation every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist reviewed Resident #3's medication regimen and explained that missing one or two doses of her medications was not a detriment to her well being. The Pharmacist continued to explain that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex. 3. Resident #4 was admitted to the facility on [DATE] with diagnoses that included hypertension. Resident #4 was admitted on [DATE] with physician orders for the following medications: -Potassium Chloride ER (used for low potassium) 20 (meq) milliequivalent tablet by mouth two times a day for hypokalemia, in Cubex A review of Resident #4's Medication Administration Record (MAR) for 08/2022 revealed the Resident's medications scheduled to be given at 6:00 PM on the day of admission 08/11/22 were documented as #9 which indicated not given by Nurse #1. A review of Resident #4's medical record revealed there was no documentation of the physician being notified of medication unavailability on 08/11/22. An interview was conducted with Nurse #1 on 08/18/22 at 10:05 AM. The Nurse confirmed she worked on 08/11/22 and admitted Resident #4 to the facility. The Nurse explained that she documented the medications as HOLD, not given because the medications had not yet arrived from the Pharmacy and she did not have access to the Cubex. The Nurse stated she was an agency nurse and the facility did not allow the agency staff to have access to the Cubex. She continued to explain that she was recently educated to call the physician if the medications were not given within a two hour time frame but stated she did not do it. On 08/19/22 at 3:00 PM during an interview with the Nurse Practitioner (NP) she explained that the nurses should have obtained the medications from the Cubex and if the ordered medications were not available in the Cubex then the nurses should have called her or the physician for further instructions. The NP stated she did not recall receiving a phone call about not having Resident #4's medications available. (continued on next page)

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Ridge Valley Center for Nursing and Rehabilitation	1000 College Street Wilkesboro, NC 28697

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #4 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medication documentation through the computer system they used and had been able to follow up with the nurses more promptly. The DON stated she needed to be more diligent in monitoring the records every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist reviewed Resident #4's medication regimen and explained that missing one or two doses of his medications was not a detriment to his well being. The Pharmacist continued to explain that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review, resident, family, and staff interview the facility failed to provide incontinent care for 1 of 3 residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: rheumatoid arthritis (RA), diabetes, anxiety, chronic pain, pressure ulcer of left and right buttock, pelvic fracture (break in bone), left humerus (upper arm) fracture, and left rib fracture. Review of an admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #1 was cognitively intact, had no behaviors or rejection of care and required total assistance of two staff members for toileting. The MDS further indicated that Resident #1 was always incontinent of bowel and bladder, was at risk of developing a pressure ulcer but had no pressure ulcers during the assessment reference period. An observation and interview were conducted with Resident #1 on 08/17/22 at 9:24 AM. Resident #1 was resting on a low air loss mattress and was positioned slightly on her right side. Resident #1 stated that at times she laid in urine for 2-3 hours and initially the staff were not turning her. Resident #1 explained that she was paralyzed from a previous stroke and could not turn herself. Resident #1 stated that about three times a week it took between 2-3 hours for staff to come in and change her when she was wet but added that the call bell response time had improved a little bit. Resident #1 explained that she laid on her back all night (previous night) no one changed her until sometime around 4:30 AM and when staff came in to change her, she was soaked and so was her bed. An interview with Resident #1's family member was conducted on 08/17/22 at 10:12 AM. The family member stated that Resident #1 had a cell phone that she always kept close to her and several times on 08/05/22 and 08/07/22 Resident #1 had called and asked the family member to come over to the facility and change her because the staff had not answered her call light. The family member stated that when Resident #1 called him to come to the facility and change her, he would ask her if the call light was on, and she confirmed that it was. The family member stated that he drove over to the facility and when he got to the facility the call light was still on and he went ahead and changed Resident #1 and repositioned her. The Wound Care Nurse was interviewed on 08/17/22 at 3:30 PM and confirmed that Resident #1 developed a wound shortly after admission to the facility. The Wound Care Nurse explained that frequently when she went to complete the wound dressing the wound would be uncovered and Resident #1 would be wet with urine. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse Aide (NA) #6 was interviewed on 08/18/22 at 11:09 AM. NA #6 stated she had been coming to the facility the last 4 weeks through an agency and confirmed she was familiar with Resident #1. NA #6 confirmed that this morning around 4:00 AM to 5:00 AM she went into check on NA #7 who had Resident #1 and NA #7 was upset and stated she was not aware that she was assigned to care for Resident #1 when she arrived for her shift at 11:00 PM. NA #6 stated to NA #7 that she would take care of Resident #1 for her. She stated that Resident #1 was soaked with urine through to the mattress and her brief was soaked as was the bedding. NA #6 stated that she provided incontinent care to Resident #1 and got her situated in the bed and as comfortable as possible. NA #6 stated that on multiple occasions she would find Resident #1 soaked with urine and few times with feces and would immediately get her changed and cleaned up . Attempts to speak to NA #7 were made on 08/18/22 and 08/19/22 were unsuccessful. The Director of Nursing (DON) was interviewed on 08/18/22 at 3:35 PM who stated that the staff should have provided consistent turning and repositioning along with frequent incontinent care to help promote good wound healing of Resident #1's wounds.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review and resident, family, staff, Nurse Practitioner and Wound Physician interviews the facility failed to complete thorough assessments or obtain measurements of a resident's pressure ulcer and implement interventions that would prevent the worsening of a pressure ulcer for 1 of 3 resident reviewed with pressure ulcers (Resident #1). Resident #1 admitted on [DATE] with a red area on her sacrum, on [DATE] the red area opened and on [DATE] the wound was an unstageable wound with 100% slough (dead tissue) that measured 3.5 centimeters (cm) x 3.5 cm x 0.4 cm. Resident #1 was hospitalized from [DATE] to [DATE] for acute cerebrovascular accident (stroke) and returned to the facility with a wound vacuum (vacuum that sucks fluid out of wounds) in place. Resident #1 was evaluated by the Wound Physician on [DATE] and the Stage 4 pressure ulcer measured 4.3 cm x 4.5 cm x 1.6 cm and contained 30% slough 15 % granulation tissue and 15 % of bone and muscle was exposed. The Wound Physician evaluated Resident #1 on [DATE] and suspected osteomyelitis that required rehospitalization and intravenous antibiotic therapy. Resident #1 expired on [DATE] due to severe sepsis and Stage 4 decubiti. Immediate jeopardy began on [DATE] when the facility identified an unstageable pressure ulcer on Resident #1 after lack of thorough assessments or interventions. The immediate jeopardy was removed on [DATE] when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of Level D (no actual harm with the protentional for more than minimal harm that is not immediate jeopardy). The findings included: Review of a Discharge Summary from the local hospital dated [DATE] read in part; Discharge Exam: Wounds: stage 2 pressure ulcer to bilateral buttock without signs or symptoms of infection. No measurements were noted. Resident #1 was admitted to the facility on [DATE] with diagnoses that included: rheumatoid arthritis (RA), diabetes, anxiety, chronic pain, pressure ulcer of left and right buttock, pelvic fracture (break in bone), left humerus (upper arm) fracture, and left rib fracture. Review of a Braden Scale for predicting pressure ulcers dated [DATE] indicated that Resident #1 was at moderate risk of developing a pressure ulcer. Review of an Admission Nursing Assessment signed by Nurse #1 and dated [DATE] indicated that Resident #1 had no skin issues. Nurse #1 was interviewed on [DATE] at 10:39 AM. Nurse #1 stated that she helped with admissions and confirmed that she had signed the Admission assessment dated [DATE] but stated she had not completed the skin assessment. She stated that the Director of Nursing (DON) completed the assessment did not enter a weight so it would not let her sign and complete the assessment so when Nurse #1 came to the facility a few days later she entered a weight then signed the assessment. Nurse #1 again stated she had not completed the skin assessment dated [DATE] she had only signed the assessment but stated the DON had opened the assessment and that was who would have done the assessments. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an admitting daily skin assessment dated [DATE] and signed by Nurse #2 on [DATE] indicated that Resident #1 had redness to her sacrum. No further description or measurements were noted on the assessment. Attempts to speak to Nurse #2 were made on [DATE], [DATE] and [DATE] and were unsuccessful. Review of a Resident Body Scan Tool dated [DATE] with no staff signature indicated that Resident #1 had a red sacrum and had handwritten on the form house barrier? (cream used for skin protection). Review of a baseline care plan dated [DATE] completed by Minimum Data Set (MDS) Nurse #1 on [DATE] indicated that Resident #1 had no pressure ulcers. Review of an admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #1 was cognitively intact, had no behaviors or rejection of care and required total assistance of two staff members for bed mobility. The MDS further indicated that Resident #1 was always incontinent of bowel and bladder, was at risk of developing a pressure ulcer but had no pressure ulcers during the assessment reference period. Review of Resident #1's physician orders dated [DATE] revealed no treatment for Resident #1's sacrum prior to [DATE]. Review of the Treatment Administration Record (TAR) dated [DATE] revealed no treatment to Resident #1's sacrum prior to [DATE]. Review of weekly skin review dated [DATE] and signed by the Wound Care Nurse on [DATE] read that Resident #1 had skin tears to lower extremities and wrist upon admission and treatment was in place. No other skin issues were noted. Review of a Situation Background Assessment and Recommendation (SBAR) dated [DATE] and electronically signed by the Wound Care Nurse read in part; area to left buttock that measured 1. 0-centimeter (cm) x 0.5 cm. Hydrocolloid (moisture retentive dressing) dressing every Monday, Wednesday, Friday. The Nurse Practitioner (NP) was notified on [DATE] at 12:00 AM. Review of a physician order dated [DATE] read; cleanse buttock with wound cleaner, apply skin prep to peri wound then apply xeroform (petroleum infused dressing) to open area and cover with a hydrocolloid dressing every Monday, Wednesday, and Friday. Review of a weekly skin review dated [DATE] and signed by the Wound Care Nurse on [DATE] read in part; sacrum upper buttock deteriorated to unstageable (full thickness tissue loss in which actual depth is completely obscured by slough). Positioning wedge provided. Treatment changed and referred to Wound Physician. The review contained no measurements or further description of the wound. Review of a physician order dated [DATE] read in part; cleanse buttock with wound cleanser, apply skin prep to peri wound. Apply calcium alginate (dressing used on wound that have heavy drainage) to open area and cover with hydrocolloid dressing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a SBAR dated [DATE] and completed by the Wound Care Nurse read in part; area was excoriated that has deteriorated. Area originally measured 1.0 cm x 0.5 cm. The NP was notified on [DATE] at 6:00 PM. Review of a weekly pressure wound observation tool dated [DATE] and completed by the Wound Care Nurse indicated that Resident #1 had a wound to her sacrum/buttock that was acquired in the facility on [DATE]. The stage of the pressure ulcer was unstageable with 100 percent of slough that measured 3.5 cm x 3.5 cm x 0.4 cm. Treatment order changed and indicated the wound had deteriorated. The provider was notified on [DATE]. Review of a physician order dated [DATE] read; cleanse buttock with wound cleanser, apply skin prep to peri wound. Apply calcium alginate with silver (dressing used to prevent bacterial penetration) to the open area and cover with hydrocolloid every Monday, Wednesday, and Friday. Review of a Significant Change MDS dated [DATE] indicated that Resident #1 was cognitively intact and had no behaviors or rejection of care. The MDS further indicated that Resident #1 required extensive assistance of two staff members for bed mobility, was always incontinent of bowel and bladder and had 1 unstageable pressure ulcer that was not present on admission. The MDS indicated that Resident #1 was on a pressure reducing device for bed. A physician order dated [DATE] read, Send to emergency room (ER) for evaluation and treatment. Review of a discharge summary from the local hospital dated [DATE] indicated Resident #1's discharge diagnoses to include: acute cerebrovascular accident, rheumatoid arthritis, unstageable sacral wound present on admission to the hospital. The summary also read; patient had a wound vac (suction machine placed over wounds to pull fluid from the wound) placed and needs to be changed on [DATE]. A wound consult obtained while in the hospital read in part; sacral wound unstageable 3.5 cm x 4.0 cm x 1.0 cm with 1. 5 tunnel (passageway under the skin) at 9:00 o ' clock extending vertical 1.5 cm. Undermining (erosion of underlying skin) noted 12:,d+[DATE]:00 1.0 cm. Wound bed with 75% coverage thin layer of yellow slough. Fascia (connective tissue) not intact. Awaiting surgical recommendations to develop treatment plan. The discharge summary further read; general surgery consulted, and no debridement was performed. Wound vacuum will be applied [DATE] and family is requesting patient to return to the nursing facility for further care. Resident #1 was readmitted to the facility on [DATE]. Review of admission assessment dated [DATE] that revealed that Resident #1 had a pressure ulcer to her sacrum that was a stage 4. No measurements were listed. The assessment also read; resident has wound vac to sacrum and multiple skin tears to bilateral arms and legs. Review of a physician order dated [DATE] read; clean wound with wound cleaner and apply Santyl (debriding agent) to wound bed prior to wound vac application every Monday, Wednesday, and Friday. Review of the August Treatment Administration Record (TAR) revealed that the wound vacuum was changed on [DATE] by the Wound Care Nurse at 5:12 PM. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an Initial Wound Evaluation and management Summary dated [DATE] read in part; Resident #1 had a pressure ulcer to the sacrum that was a stage 4 and measured 4.3 cm x 4.5 cm x 1.6 cm with moderate serous drainage. The wound contained 30% slough, 55% granulation tissue, and 15% of bone and muscle. The treatment plan included: pack wound with Dakin's (bleach type solution) and cover with a large gauze pad after prepping the wound edges with skin prep every day. The recommendations also indicated group 2 mattress (low air loss mattress). The evaluation was electronically signed by the Wound Physician. Review of a physician order dated [DATE] read; cleanse wound of the sacrum with Dakin's solution, skin prep to peri wound pack wound with Dakin's solution and gauze, cover with padded dressing every day and as needed. An observation and interview were conducted with Resident #1 on [DATE] at 9:24 AM. Resident #1 was resting on a low air loss mattress and was positioned slightly on her right side. Resident #1 stated that she had just received her low air loss mattress on [DATE] and she was being seen by the Wound Physician who was trying to heal the wound that was on her sacrum. She stated that her wound was a Stage 4 and stated, it was very painful and added when I came to the facility, I had no wounds on my sacral area. Resident #1 explained that she had been at the facility for about 2 weeks when her sacrum started hurting and she asked the staff to look at it and they found a red spot and then it got worse and now is a hole. Resident #1 stated that at times she laid in urine for ,d+[DATE] hours and initially the staff were not turning her. Resident #1 explained that she was paralyzed from a previous stroke and could not turn herself. The staff were completing wound care as the Wound Physician ordered with Dakin's solution. Resident #1 stated that about three times a week it took between ,d+[DATE] hours for staff to come in and change her when she was wet but added that the call bell response time had improved a little bit. Resident #1 explained that she laid on her back all night (previous night) no one changed her until sometime around 4:30 AM and when staff came in to change her, she was soaked and so was her bed. Then the Nurse Aide (NA) that changed her forgot to put the positioning wedge behind her so when NA #4 got there she had fixed it. NA #4 was interviewed on [DATE] at 9:23 AM who confirmed that she worked at the facility through an agency. NA #4 confirmed that when she arrived for her shift yesterday ([DATE]) Resident #1 did not have her positioning wedge behind her back, so she placed the wedge behind Resident #1 and covered it with a towel as the resident requested her to do. An observation of wound care was completed on [DATE] at 10:32 AM along with the Wound Care Nurse and NA #2. The Wound Care Nurse was observed to perform hand hygiene and don clean gloves and then remove a dressing from Resident #1's sacral area. Once the dressing was removed there was large hole over the sacral area with bone and muscle exposed. There was a dark black area on the edge of the wound. The wound was clean with light pink tissue noted to the wound bed. Resident #1 asked the Wound Care Nurse to take a picture of the wound and the Wound Care Nurse did as asked. The Wound Care Nurse stated to NA #2 that the area started out as an excoriated area and began cleaning the wound with Dakin's solution. Once the wound was clean with the Dakin's solution the Wound Care Nurse removed her gloves and performed hand hygiene and donned clean gloves. She began packing the wound with gauze soaked in Dakin's solution and placed it in the wound and covered with a padded dressing as ordered. Once the treatment was completed Resident #1 was again placed slightly on her right side where she had been positioned at the start of the wound observation and during an earlier observation of Resident #1 on the same day. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Wound Care Nurse was interviewed on [DATE] at 3:30 PM who confirmed that she reviewed each new admission either the day of admission or the next day. The Wound Care Nurse stated admissions that came in on Friday or over the weekend were reviewed on Monday. She added that she rounded with the Wound Physician each week and once his reports were in the system, she would review them and carry out any new orders. The Wound Care Nurse stated that when Resident #1 came to the facility she had a mepilex (dressing) to her sacral area and when it was removed there was nothing under it. The Wound Care Nurse confirmed that she had seen Resident #1 during her first week after admission and she had no sacral wound then started to get excoriated and hydrocolloid was ordered three times a week. The Wound Care Nurse stated that someone was taking my dressings off in between her three time a week changes and they were not replacing them. The Wound Care Nurse explained that frequently when she went to complete the wound dressing the wound would be uncovered and Resident #1 would be wet with urine. Initially the staff were just using barrier cream which the Wound Care Nurse indicated was standard protocol and after Resident #1 had been there about 2 weeks we found the excoriated area and hydrocolloid was initiated then a week later the wound was unstageable and covered in slough. At times the staff were turning her but at times they were not and if the staff had been changing her like they should have been it would not have progressed that quickly. The Wound Care Nurse added I think the lack of routine incontinent care and lack of consistent offloading contributed to the development of this wound. The Wound Care Nurse stated she did provide the staff with a positioning wedge but Resident #1 did prefer the use of pillows for turning and repositioning. An interview with Resident #1's family member was conducted on [DATE] at 10:12 AM. The family member stated that Resident #1 had a cell phone that she always kept close to her and several times on [DATE] and [DATE] Resident #1 had called and asked the family member to come over to the facility and change her because the staff had not answered her call light. The family member stated that when Resident #1 called him to come to the facility and change her, he would ask her if the call light was on, and she confirmed that it was. The family member stated that he drove over to the facility and when he got to the facility the call light was still on and he went ahead and changed Resident #1 and repositioned her. The family member reported on numerous occasions Resident #1 would call him and report no one would answer her call light and he would call the facility and have someone go and check on Resident #1. The family member confirmed that the air mattress was placed on [DATE]. NA # 3 was interviewed on [DATE] at 9:03 AM. NA #3 confirmed that she had cared for Resident #1 shortly after she admitted to the facility in [DATE]. She stated that Resident #1 would ring her call light and ask to be changed and when they changed her, they would try to turn her off her bottom, but she was in a lot of pain so a lot of times it was just slightly turning her from side to side. NA #3 also confirmed that Resident #1 required at a minimum of two people to turn and change her and at times three people due to her pain but could not recall if Resident #1 had any wounds or not. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NA #6 was interviewed on [DATE] at 11:09 AM. NA #6 stated she had been coming to the facility the last 4 weeks through an agency and confirmed she was familiar with Resident #1. She stated that she was very difficult to turn due to her pain. She stated that initially Resident #1's wound was just some very mild redness then she was off a few days and when she came back it was much worse. NA #6 stated that she had found the wound several times with no dressing on it and she would always report it to the nurse. NA #6 confirmed that this morning around 4:00 AM to 5:00 AM she went into check on NA #7 who had Resident #1 and NA #7 was upset and stated she was not aware that she was assigned to care for Resident #1 when she arrived for her shift at 11:00 PM. NA #6 stated to NA #7 that she would take care of Resident #1 for her. She stated that Resident #1 was soaked with urine through to the mattress and her brief was soaked as was the bedding. NA #6 stated that she provided incontinent care to Resident #1 and got her situated in the bed and as comfortable as possible. NA #6 stated that on multiple occasions she would find Resident #1 soaked with urine and few times with feces and would immediately get her changed and cleaned up. She added that on [DATE] she had moved Resident #1 to her chair so the low air loss mattress could be applied to her bed. Attempts to speak to NA #7 were made on [DATE] and [DATE] were unsuccessful. NA #5 was interviewed on [DATE] at 11:13 AM. NA # stated that she worked at the facility through an agency and had been coming to the facility for about a month. NA #5 stated that she was working the day Resident #1 was admitted . NA #5 stated that Resident #1 was able to ring her call bell and let us know what she needed, she had a lot of pain from her fractures, so we really did not turn her it was just propping her on each side to relieve the pressure from her bottom. NA #5 stated she recalled Resident #1 had ,d+[DATE] nickel size areas that were light red on her buttock and that she applied barrier cream when she provided incontinent care and notified the nurse but could not recall which nurse and stated that the nurse was already aware of the areas. The DON was interviewed on [DATE] at 11:37 AM. The DON stated she did not assess Resident #1 upon admission, she stated she had opened the assessment then Nurse #1 completed the assessment and signed it. The DON explained that Nurse #1 who signed the Admission Assessment should have looked at Resident #1's skin and taken measurements of anything that was present even if was a red area. The DON stated that when she reviewed the Discharge Summary from the hospital dated [DATE], she read that Resident #1 had a stage 2 pressure ulcer and when she had reviewed Resident #1's admission to the facility and there were no skin issues noted. She asked the Wound Care Nurse to go and complete another assessment on [DATE] and no sacral area was noted. She explained that Resident #1 needed to be turned and repositioned with frequent incontinent care provided due to her limited mobility from a previous stroke. The DON stated that Resident #1 drank more than she ate but her family brought her lots of stuff from home, and she would always eat that food and was not losing weight. The DON stated that when she saw the SBAR completed by the Wound Care Nurse on [DATE] she was aggravated because she had asked the Wound Care Nurse to review Resident #1 shortly after admission when she saw the discrepancy (difference from the discharge summary to the admission assessment completed at the facility) from the discharge summary and the initial Admission Assessment. She expected the Wound Care Nurse to review all admission that had come in the previous 24 hours or over the weekend, assess any skin issues and ensure a treatment was in place. A follow up interview was conducted with the DON on [DATE] at 3:35 PM. The DON stated that the facility staff should have obtained an air mattress more quickly when Resident #1's wound first developed and provided consistent turning and repositioning along with frequent incontinent care to help promote good wound healing. (continued on next page)

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	345133	A. Building B. Wing	09/01/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NP was interviewed on [DATE] at 4:31 PM who confirmed that she was made aware of the development of Resident #1's wound could not recall the exact date but had been made aware. She stated that shortly after being made aware of a wound, the wound deteriorated, and she had a large hole in her sacrum. She added that Resident #1 was referred at some point to the Wound Physician and the NP stated that she had observed the wound but could not recall the exact date but stated the wound had slough and was easily packed with gauze. The NP stated that she routinely read through the Wound Physician notes but generally the Wound Physician handled the significant wounds in the facility. The Wound Physician was interviewed on [DATE] at 2:35 PM and confirmed that this would be his second visit with Resident #1. He stated that Resident #1 had diabetes, RA and was immunocompromised along with her paralysis, immobility, and incontinence placed her at risk for skin breakdown. He explained that if the skin was exposed to urine and feces that would not help the skin at all. The Wound Physician stated if the staff were not cleaning Resident #1 well enough then, the wound could get worse. The Wound Physician was made aware of the dark black edges of the wound observed on [DATE] and he stated that indicated a need for further offloading. One thing he noticed his first visit on [DATE] was she was not on an air mattress which would encourage wound healing. The Wound Physician also explained that the rapid increase in size was from lack of offloading, poor nutrition, and acute health decline. He stated he questioned why she was on a group 1 mattress (not an air mattress) and why she would not have been on a low air loss mattress sooner. A follow up interview was conducted with the Wound Physician on [DATE] at 6:40 PM. The Wound Physician stated after examining Resident #1 he was very suspicious that she may have osteomyelitis (infection of the bone) and was going to start working her up for that. The first step was to order some lab work and go from there. The Wound Physician stated that depending on her lab work Resident #1 may need to go back to the hospital for treatment. He stated that it was very hard to say if Resident #1's wounds were avoidable or unavoidable but stated they were always declining along with her overall health. A follow up interview was conducted with the Wound Physician on [DATE] at 5:18 PM. The Wound Physician indicated that the lab work he ordered on [DATE] had come back and indicated that Resident #1 was mounting a significant infection and needed to be worked up very quickly, like in the next hour. The Wound Physician indicated that Resident #1 could die from complications of sepsis, and he must work quickly and was going to send her to the ER for evaluation and treatment. Review of a physician order dated [DATE] read; send to ER for evaluation. A follow up interview with the Wound Physician was conducted on [DATE] at 10:24 AM and stated that Resident #1 was sent to the hospital on [DATE] and expired in the early hours of [DATE]. He indicated the cause was likely from the osteomyelitis of the sacral wound but with her co-morbidities it would be hard to tell for sure. Review of Resident #1's death certificate indicated her cause of death was severe sepsis and Stage 4 decubiti (pressure sore that reaches muscle, tendon, and bone) left buttock. The Administrator was notified of the Immediate Jeopardy (IJ) on [DATE] at 11:22 AM. The facility provided the following IJ removal plan: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F686: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: The facility failed to fully assess including measuring a resident's wound and failed to implement interventions that would prevent the worsening of a pressure ulcer for 1 of 3 resident reviewed with pressure ulcers (Resident #1). Because all residents are at risk upon admission when a wound is not fully assessed and when preventative care is not provided to prevent the worsening of a pressure ulcer, the following plan has been devised: On [DATE], licensed nurses completed head-to-toe skin assessments on all facility residents to identify changes in skin integrity. Residents identified with new changes in skin condition documented on a skin assessment form and were reported to the physician and/or nurse practitioner via phone by the licensed nurse and follow-up orders obtained as appropriate. The Minimum Data Set (MDS) nurse or Licensed Nurse updated resident care plans to reflect skin changes for actual or potential pressure wounds and preventative interventions by [DATE]. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On [DATE], the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO), Regional Director of Clinical Services (RDCS), Wound Nurse, MDS Nurse, Wound Practitioner and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review the facility Pressure Injury Prevention and Management Policy and to determine root cause of deficient practice. By root cause analysis, the QAPI committee determined that the facility failed to follow the Pressure Injury Prevention and Management Policy by failing to ensure that upon admission the accurate completion of skin assessments to identify, address resident skin impairments and implement wound prevention strategies for high-risk residents by the Licensed Nurses and Nurse Aides. A plan was formulated by the QAPI committee to address the identified issue to include a review of education, audit/monitoring needs, and QAPI committee responsibilities in reviewing for compliance. On [DATE], the DON and RDCS completed education to current facility and agency Licensed Nurses and Nurse Aides on the facility Pressure Injury Prevention and Management Policy. Education included the following: a) the facility's wound care protocol and the expectation of each Licensed Nurse for wound care prevention including assessing all wounds when discovered, implementing interventions to mitigate risk of deterioration and ensure effective prevention and treatment occurs. b) the facility's protocol on completing skin assessments to include accurate description and measurements and role of Licensed Nurse. c) Skin Assessments to be completed upon admission/readmission and weekly thereafter by the licensed nurse. Weekly skin assessments will be ordered on the Treatment Administration Record. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d) the facility's protocol on Nurse Aides inspecting skin during activities of daily living (ADL) care such as when performing incontinence care and bathing to identify any alteration in residents skin integrity and to report changes to licensed nurse on duty. Or reported pain to the licensed nurse supervisor e) interventions to reduce the risk of a pressure ulcer development or worsening (turning/reposition, hydration, routine incontinence care, pressure relieving cushions/wedges) and f) Licensed Nurses and Nurses' Aides educated on frequency of incontinence care, turning and repositioning and reporting to the nurse if wound dressings are soiled or comes off during care. Licensed nurse on duty to replace dressing. g) following resident physician orders and plan of care to treat or prevent pressure wounds. Licensed Nurses and Nurse Aides not receiving education on [DATE] will not be allowed to work until completed. The DON will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the RDCS on [DATE]. Education will also be included during orientation for newly hired facility and agency Licensed Nurses and Nurse Aides, to be completed by Director of Nursing or Nurse Manager. Effective [DATE], the facility has hired a full-time, wound-certified licensed nurse who began working in facility on [DATE]. Effective [DATE], the wound certified licensed nurse will review resident skin condition upon admission, weekly and with changes in condition. Nurse aides will complete body audits during ADL care and will report skin concerns, soiled, uncovered wounds, or reports of pain to the licensed nurse on duty for further assessment. New skin concerns will be reported to the physician and/or nurse practitioner upon findings by the licensed nurse for follow-up treatment via phone. MDS Nurse will ensure care plans for residents with actual/potential pressure wounds include pressure relieving interventions to prevent further breakdown. Pressure relieving devices and interventions will be added to the Kardex for Nurse Aide communication. The DON will review newly admitted /readmitted residents in daily clinical meeting to monitor for the accurate completion of skin assessments and treatment to prevent and heal pressure wounds and ensure that pressure relieving devices are put into place These expectations were communicated on [DATE] by the Administrator to the wound nurse and clinical team Effective [DATE], the Director of Nursing or Licensed Nurse will complete surveillance care rounds to validate incontinence care is being completed routinely, pressure relieving devices are in place per resident plan of care. Effective [DATE], the Administrator and Director of Nursing will be responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged Date of IJ Removal: [DATE] (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A credible allegation validation of pressure ulcers was conducted in the facility on [DATE]. All residents skin assessments were reviewed and ensured all areas were appropriately documented in the medical record that included description of wound and measurements if applicable. The root cause analysis was reviewed along with training materials used to reeducate the staff. The in-service training records indicated that all staff including agency nursing staff and facility nursing staff including Nurse Aides, Nurses, and Medication Aides had been educated on the facility ' s policy and procedure for preventing and treating pressure ulcers. Interview with both agency staff and facility nursing staff revealed that they had received the education on wound prevention that included frequent incontinence rounds, frequent turning, and repositioning, assessing residents' skin on admission and then weekly, reporting of skin changes, and addressing pain that interfered with frequent incontinence round or turning. The facility's Quality Assurance (QA) team met on [DATE] to discuss and implement the plan. The facility's IJ removal date of [DATE] was validated.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, staff, resident, Nurse Practitioner (NP) and Wound Physician interview the facility failed to stop a wound dressing change when a resident experienced pain on a pain scale of 12 and when reported to the NP the NP failed to assess the residents sudden change in pain for 1 of 3 residents reviewed for pressure ulcers (Resident #1). Resident #1 was visibly crying, moaning, hollering, and pulling away as the staff were packing her sacral wound and the Wound Care Nurse did not stop the treatment or ask the resident if she wanted her to continue. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: rheumatoid arthritis (RA), diabetes, anxiety, chronic pain, pressure ulcer of left and right buttock, left superior and inferior pelvic fracture, left humerus fracture, and left rib fracture. Review of an Admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #1 was cognitively intact, had no behaviors or rejection of care and required extensive to total assistance for activities of daily living. The MDS further indicated that Resident #1 received scheduled pain medication, endorsed pain almost constantly that made it hard to sleep and affected her to day-to-day activities and rated her pain at a 7 on pain scale. Review of a physician order dated 08/05/22 read; Gabapentin (for neuropathy pain) 300 milligrams (mg) by mouth at bedtime for RA. Acetaminophen 325 mg give 2 tablets by mouth every 6 hours for mild pain, Oxycodone (opioid pain reliever) 10 mg by mouth every 6 hours as needed for pain. Review of the Medication Administration Record (MAR) dated August 2022 revealed on 08/17/22 Resident #1 requested and received Oxycodone 10 mg by mouth at 6:36 AM and again at 3:45 PM and both times were effective. An observation and interview were conducted with Resident #1 on 08/17/22 at 9:24 AM. Resident #1 was resting on a low air loss mattress and was positioned slightly on her right side. Resident #1 stated she was being seen by the Wound Physician who was trying to heal the wound that was on her sacrum. Resident #1 proceeded to say that the wound on her bottom was a stage 4 and was very painful and currently her pain was a 7 on pain scale and at its worst was a 9 on a pain scale. She reported that the staff completed her wound care as directed by the Wound Physician but stated it is so painful sometimes they give me pain medication, but I never know when the nurse is coming to do my treatment, so it is hard to get pain medication before the treatment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An observation of wound care was made on 08/17/22 at 3:00 PM along with the Wound Care Nurse. Upon entering the room Resident #1 stated to the Wound Care Nurse, I know you are here to torture me again. The Wound Care Nurse was observed to perform hand hygiene and don clean gloves and then she removed the dressing from Resident #1's sacral area to expose a large hole with muscle and bone exposed. As the Wound Care Nurse began to clean the wound with Dakin's solution (bleach like solution) Resident #1 let out a scream. She continued to clean the wound and Resident #1 began to thrust her hips forward to pull away from the Wound Care Nurse. Resident #1 stated, the pain medication is not helping, and my pain is a 12 and I usually tolerate pain well. The Wound Care Nurse stated to Nurse Aide (NA) #2 that was assisting with the wound change, Resident #1 tolerated the pain from her recent fracture better then she was tolerating the pain from the wound. As the Wound Care Nurse began to pack the wound with gauze soaked with Dakin's solution Resident #1 started moaning and stated, this is awful and continued to pull away from the Wound Care Nurse and let out a scream to which the Wound Care Nurse replied, I am almost done honey. Resident #1 took a gasp of air and stated oh then asked the Wound Care Nurse are you done to which she replied almost. Resident #1 was noted to be crying with liquid falling from her eyes rolling down the air mattress to the floor. The Wound Care Nurse continued to pack the wound and then covered the wound with a dressing. The Wound Care Nurse and NA #2 proceeded to then place a dry brief on Resident #1 who continued to cry. The Wound Care Nurse stated to Resident #1 she was going to speak to the Nurse Practitioner (NP) to get her something stronger for pain. A follow up interview and observation were conducted with Resident #1 on 08/17/22 at 3:25 PM. Resident #1 was resting in bed on her right side. She continued to cry and stated, it hurts so bad, and I cannot take much more. The Wound Care Nurse was interviewed on 08/17/22 at 3:30 PM and stated that this was the first time that Resident #1 had ever reacted to a dressing change the way she did today (08/17/22). She stated that Resident #1 had received pain medication prior to the treatment and it shocked me the way she reacted. She stated Resident #1 does have pain but has never reacted the way she did today. Normal protocol would have been to stop the dressing change when Resident #1 stated she was hurting or began having nonverbal signs of pain but at the time I just wanted to get it done so the pain would be done. If I would have stopped, she would have never let me finish and I did not want to leave the wound uncovered. Again, she stated I probably should have stopped but I am leaving the wound open? A follow up interview with the Wound Care Nurse was conducted on 08/17/22 at 4:17 PM. The Wound Care Nurse stated that she spoke to the NP about Resident #1's pain and she replied that the NP stated, I will absolutely not increase her medication because she has a history of narcotic abuse. The Wound Care Nurse explained that when Resident #1 first admitted to the facility she was constantly on the call light for pain medication. The NP was interviewed on 08/17/22 at 4:31 PM. The NP stated that when Resident #1 first admitted to the facility she was on a lot of oxycodone and I said no way I am comfortable with that and referred her to pain management clinic. When told about Resident #1's pain during the wound care observation on 08/17/22 the NP replied, I think her pain was not real, I have never seen any signs of pain. She stated, I have been in the room during wound care, and she laid there peacefully and quietly. She stated that Resident #1 had poor kidney function and chronic opioid abuse and I think her pain was a show. The NP stated she was covering Resident #1 with oxycodone 10 mg 4 times a day and again stated that she had never seen Resident #1 with signs of pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a physician order dated 08/17/22 read; refer to pain management clinic. The Wound Physician was interviewed on 08/18/22 2:35 PM. The Wound Physician was made aware of the wound observation from 08/17/22 and indicated that he had evaluated Resident #1 last week on 08/11/22 and she had some discomfort but nothing like the pain that was described from the 08/17/22 wound change. He stated that he was suspicious that Resident #1 has some early osteomyelitis (infection of the bone) developing and that was causing her increase pain. The Wound Physician stated he was going to go and evaluate Resident #1 and determine the next course of action. A follow up interview was conducted with the NP on 08/18/22 at 4:23 PM. The NP stated that Resident #1 had pain medication on 08/18/22 at 12:00 PM but had instructed the staff to go ahead and give her extra pain medication so the Wound Physician could examine her on his rounds in the facility. NA #2 was interviewed on 08/18/22 at 4:33 PM and stated that he had never seen Resident #1 display pain like she did during the wound care observation on 08/17/22. He stated that was the first time he saw her crying, moaning, or pulling away during wound care. A follow up interview with the Wound Physician was made on 08/18/22 at 6:40 PM. He stated that he had evaluated Resident #1 and her pain was much more significant than on his last visit and he was going to immediately start a workup for osteomyelitis that included lab work and a white blood cell count. A follow up interview with the Wound Physician was conducted on 08/19/22 at 5:18 PM. He stated that the lab work he ordered on 08/18/22 indicated that Resident #1's white blood cell count was 22.5 (high) and was very concerning for acute osteomyelitis and would explain the increase in her pain. He stated that on 08/17/22 when Resident #1 had the sudden change in her pain it should have been reported to the provider and the resident should have been assessed and a workup including lab work that included a white blood cell count to try and figure out why the change in her pain. The Wound Physician explained that Resident #1 had RA and was immunosuppressed, and her pain tolerance was much different than a normal person without RA and the increase in pain was her first sign that something more severe was going on. The Director of Nursing (DON) was interviewed and stated that the Wound Care Nurse had told her about the wound observation with Resident #1 on 08/17/22. She stated she asked the Wound Care Nurse if she stopped the wound care and she stated no. The DON stated she educated the Wound Care Nurse that she should have stopped and immediately reported it to the provider for further assessment and appropriate pain management.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record reviews, staff and Pharmacist interviews the facility failed to prevent significant medication errors when medications were not obtained and administered per the physician orders for 3 of 3 residents (Resident #2, #3 and #4) reviewed for medications. The findings include: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included restless leg syndrome, chronic obstructive pulmonary disease, hypertension, atrial fibrillation, pain, diabetes mellitus and nondisplaced fracture of right femur. Resident #2 was admitted on [DATE] with physician orders for the following medications: Gabapentin (given for nerve pain) 600 (mg) milligrams one tablet by mouth at bedtime for pain management, available in Cubex, (a tower of medications available for the staff to pull medications from until the residents' medications arrive from the pharmacy) Tizanidine HCL (a muscle relaxant) 4 mg tablet by mouth at bedtime for muscle spasms, not in Cubex Brovana Nebulization Solution (a bronchodilator) inhale 2 (ml) milliliters orally via nebulizer two times a day for chronic obstructive pulmonary disease, not in Cubex Budesonide Suspension Solution (a steroid) inhale 2 ml orally via nebulizer two times a day for chronic obstructive pulmonary disease, not in Cubex Carvedilol (given to lower blood pressure) 25 mg tablet by mouth two times a day for hypertension, in Cubex Eliquis (a blood thinner) 5 mg tablet by mouth two times a day for atrial fibrillation, in Cubex Hydrocodone-Acetaminophen (an analgesic) 10-325 mg tablet by mouth two times a day for pain, in Cubex A review of Resident #2's Medication Administration Record (MAR) for 06/2022 revealed the Resident's medications scheduled to be given at 8:00 PM on the day of admission 06/09/22 were documented as #9 which indicated not given by Nurse #3. The MAR further revealed that at 8:00 AM on 06/10/22 the Brovana and Budesonide nebulizing treatments were documented as #5 which indicated Hold by the Wound Care Nurse (WCN). A review of Resident #2's medical record revealed there was no documentation that the physician was notified of medication unavailability on 06/09/22. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 2:35 PM during an interview with the Wound Care Nurse she confirmed she worked on 06/10/22 for the 8:00 AM medication pass and did not give Resident #2 his medications. The Wound Care Nurse explained that day was the first day she was pulled to the medication cart and had never had orientation to the medication system. She stated she was supposed to be trained by the previous Director of Nursing (DON), but the DON was not available when she needed her counsel on issues. One of the issues were the breathing treatments for Resident #2, she could not find them, so she documented in the nurses' notes to hold per nurses' judgement. The Wound Care Nurse explained that she now understood that she should have looked in the Cubex for the medication and if not available she should have notified the physician for a substitute or further direction but she didn't know that at the time of the incident. The Wound Care Nurse stated she did not have access to the Cubex. On 08/19/22 at 8:45 AM an interview was conducted with Nurse #3 who confirmed she worked the 7:00 PM to 7:00 AM shift on 06/09/22 and did not give the 8:00 PM scheduled medications to Resident #2. The Nurse explained that she had access to the Cubex that she could have pulled the medications from if the medications were in the Cubex but she figured that since the medications were not antibiotics then it would not hurt to wait for the Resident's medications to be delivered from the Pharmacy which would be in the early morning hours. The Nurse continued to explain that she was trained to obtained the ordered medications from the Cubex if available and if not then she should have contacted the physician for a substitute or further directions but she did not do that and added she must have been busy that night. During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #2 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist reviewed Resident #2's medication regimen and explained that missing one or two doses of his medications was not a detriment to his condition because most of the medications were long lasting. The Pharmacist continued to explain that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included deep vein thrombosis, anxiety, hypertension, post traumatic stress syndrome. Resident #3 was admitted on [DATE] with physician orders for the following medications: Diazepam (used for anxiety) 5 mg tablet give 0.5 tablet by mouth at bedtime for anxiety, not in Cubex (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cardura (used to lower blood pressure) 1 mg tablet by mouth at bedtime for hypertension, not in Cubex Minipress (used to lower blood pressure) 1 mg capsule by mouth at bedtime for hypertension, not in Cubex Eliquis (a blood thinner) 5 mg tablet by mouth two times a day for deep vein thrombosis, in Cubex Oxcarbazepine (a mood stabilizer) 150 mg tablet by mouth two times a day for post traumatic stress syndrome, not in Cubex A review of Resident #3's Medication Administration Record (MAR) for 08/2022 revealed the Resident's medications scheduled to be given at 9:00 PM on the day of admission 08/05/22 by Nurse #1 but were documented as #9 which indicated not given. A review of Resident #3's medical record revealed there was no documentation of the physician being notified of unavailability of medications on 08/05/22. An interview was conducted with Nurse #1 on 08/18/22 at 10:05 AM. The Nurse confirmed she worked on 08/05/22 and admitted Resident #3 to the facility. The Nurse explained that she documented the medications as HOLD, not given because the medications had not yet arrived from the Pharmacy and she did not have access to the Cubex. She continued to explain that she would have called the physician and asked for substitutes and she would have documented it in the Resident's medical record. During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #3 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medications not given through the computer system used by the facility and checked the documentation every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist reviewed Resident #3's medication regimen and explained that missing one or two doses of her medications was not a detriment to her well being. The Pharmacist continued to explain that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex. 3. Resident #4 was admitted to the facility on [DATE] with diagnoses that included deep vein thrombosis. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 was admitted on [DATE] with physician orders for the following medications: Xarelto (a blood thinner) 20 mg tablet by mouth one time a day for deep vein thrombosis, in Cubex A review of Resident #4's Medication Administration Record (MAR) for 08/2022 revealed the Resident's medications scheduled to be given at 6:00 PM on the day of admission 08/11/22 were documented as #9 which indicated not given by Nurse #1. A review of Resident #4's medical record revealed there was no documentation of the physician being notified of medication unavailability on 08/11/22. An interview was conducted with Nurse #1 on 08/18/22 at 10:05 AM. The Nurse confirmed she worked on 08/11/22 and admitted Resident #4 to the facility. The Nurse explained that she documented the medications as HOLD, not given because the medications had not yet arrived from the Pharmacy and she did not have access to the Cubex. The Nurse stated she was an agency nurse and the facility did not allow the agency staff to have access to the Cubex. She continued to explain that she was recently educated to call the physician if the medications were not given within a two hour time frame but stated she did not do it. During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Resident #4 did not receive his medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she educated all the nurses on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medication documentation through the computer system they used and had been able to follow up with the nurses more promptly. The DON stated she needed to be more diligent in monitoring the records every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist reviewed Resident #4's medication regimen and explained that missing one or two doses of his medications was not a detriment to his well being. The Pharmacist continued to explain that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37280 Based on record reviews, staff and Pharmacist interviews the facility failed to provide effective oversight to ensure nurses obtained and administered medications as ordered for newly admitted residents. This practice resulted in missed doses of medications for 3 residents (Resident #2, #3 and #4). The findings include: This tag is cross-referred to: F 658- Based on record reviews and staff, Nurse Practitioner and Pharmacist interviews the facility failed to administer physician ordered medications for 3 of 3 residents (Resident #2, Resident #3 and Resident #4) reviewed for medications. F 760- Based on record reviews, staff and Pharmacist interviews the facility failed to prevent significant medication errors when medications were not obtained and administered per the physician orders for 3 of 3 residents (Resident #2, #3 and #4) reviewed for medications. During an interview with the Administrator and Director of Nursing (DON) on 08/19/22 at 4:30 PM the DON explained that she was not aware that Residents #2, #3 or #4 did not receive their medications after admission but she recently identified the issue with not obtaining the medications from the Cubex on a recent admission. She stated she was aware that the agency nurses did not have access to the Cubex so she educated all the nurses (facility and agency) on the procedure of obtaining the medications and was making more nurses available to have access to the Cubex. The DON could not explain why Resident #4 did not get his medications because he was admitted after she had educated all the nurses on the Cubex. The DON continued to explain that she informed the nurses to notify her when a medication was not available in the Cubex. The DON stated she could now monitor the medication documentation through the computer system they used and had been able to follow up with the nurses more promptly. The DON stated she needed to be more diligent in monitoring the records every day. The Administrator explained that it was not acceptable for the residents not to receive their medications and she would review the process of obtaining medications. An interview was conducted with the Pharmacist Consultant on 08/20/22 at 10:20 AM. The Pharmacist explained that they had a system set up where the nurses should obtain available medications from the Cubex and if the ordered medications were not available in the Cubex then the nurse should call the physician for a substitution if possible. He explained if the medication was needed before the next routine delivery of medications to the facility then the Pharmacy could obtain the medication from the local back up Pharmacy and have it delivered to the facility. The Pharmacist stated the facility decided who had access to the Cubex.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, staff interview, and the Center for Disease Control (CDC) COVID-19 Data Tracker for the county transmission rate the facility failed to follow the CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates when 1 of 1 wound care personnel (Wound Care Nurse) failed to wear eye protection while performing wound care for 1 of 3 residents who required wound care (Resident #1). The facility also failed to change their PPE when exiting 2 of 10 residents room located on the quarantine unit (Resident #9 and Resident #10) who were under enhanced contact droplet precautions. This deficient practice occured while the facility was in outbreak status with one staff member testing positive for COVID-19 on 08/14/22 and another testing positive on 08/15/22. The findings included: CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic updated on 09/10/21 indicated the following information under the section Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP): If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), the HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. On 08/12/22 and again on 08/17/22 the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker was reviewed. The CDC Data Tracker revealed that the county where the facility was located had a high level of community transmission for COVID-19. 1. An observation of wound care for Resident #1 was made on 08/17/22 at 3:00 PM along with the Wound Care Nurse. Upon entering Resident #1's room for wound care the Wound Care Nurse was observed to have her goggles and personal glasses on top of her head. She proceeded to perform hand hygiene and don clean gloves and removed Resident #1's soiled dressing from her sacral area. Once the dressing was removed, she doffed her gloves and performed hand hygiene and again donned cleaned gloves to apply a new dressing to Resident #1's sacral area. The Wound Care Nurse's goggles and personal glasses remained on top of her head. The Wound Care Nurse was observed to complete the dressing change to Resident #1's sacral area while her goggles and personal glasses remained on top of her head. The Wound Care Nurse was interviewed on 08/17/22 at 3:30 PM. The Wound Care Nurse stated that all staff were to wear goggles or eye protection in resident care areas including during wound care. She stated that she can not see without her glasses, and she put them both on top of her head and forgot to put them on during wound care with Resident #1. The Director of Nursing (DON) was interviewed on 08/18/22 at 3:35 PM. The DON confirmed that the facility was in a county of high transmission rate for COVID-19 and confirmed that all staff should wear eye protection while in resident care areas including during wound care. The DON stated that the Wound Care Nurse should have had her goggles or eye protection in place during wound care on 08/17/22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37280 The CDC guidelines entitled Responding to Coronavirus (COVID-19) in Nursing Homes last updated on 4/30/2022 read in part All recommended COVID-19 PPE (Personal Protective Equipment) should be worn during care of residents under observation, which includes use of N95 or higher-level respirator (or face masks if a respirator is not available), eye protection (goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. A review of the facility's policy titled Novel Coronavirus Prevention and Response revised 06/15/22 indicated 6. Procedure when COVID-19 is suspected or confirmed: * Implement standard, contact and droplet precautions. Wear gloves, gowns, goggles/face shields and a NIOSH-approved N95 or equivalent or higher-level respirator upon entering room and when caring for the resident. * Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection. A Special Droplet Contact Precautions sign provided by the facility on 08/17/22 indicated All Healthcare Personnel must: Clean hands before entering and when leaving room, Wear gown when entering room and remove before leaving room, Wear N95 or higher level respirator before entering the room and remove after exiting, Protective eyewear (face shield or goggles) and Wear gloves when entering the room and remove before leaving. During an interview conducted with the Administrator on 08/17/22 at 9:00 AM she reported the facility utilized resident rooms 146 through 160 for the Quarantine rooms and at the time of the interview there were six residents who resided on that hall which include Resident #9 room [ROOM NUMBER]. Resident #10 was admitted on [DATE] (after the interview) to room [ROOM NUMBER]. 2. On 08/17/22 at 3:00 PM a continuous observation was made of the Social Worker (SW) donning a gown and gloves (she already had a KN95 mask on) outside Resident #9's room (149) who was under Special Droplet Contact Precautions for being newly admitted on [DATE] and unvaccinated. The SW wore her personal glasses and did not don eye protection or goggles. At 3:18 PM the SW exited the room without the gown and gloves but had her KN95 mask on. At 3:18 PM on 08/17/22 an interview was conducted with the Social Worker who explained she went into the Resident's room to obtain his social assessment and she removed the gown and gloves and washed her hands before she exited the Resident's room. She stated she usually wore eye protection but today she had her glasses on and thought that would suffice. The SW continued to explain that she did not replace her KN95 mask when she came out of the room because she always wore her personal mask as does everyone else. The SW read the signage posted on the Resident's door and stated she should have applied the goggles and N95 mask provided by the facility (which was available in the PPE tower) then put her KN95 mask back on after she was finished. The SW stated the last inservice training she had attended on infection control was back in June 2022 and she was taught to wear eye protection or goggles. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/22 at 3:35 PM an interview was conducted with the Director of Nursing (DON) who also served as the Infection Control Nurse (ICN). The DON explained that approximately a month ago she provided infection control education for both shifts that included donning/doffing PPE, the different types of Precautions, and the Quarantine unit. The DON continued to explain that the staff were supposed to remove the gowns and gloves and wash their hands while in the rooms then replace their masks and eye protection after they exit the rooms. She stated the staff could wear their personal PPE as long as it was not the PPE worn in the rooms of residents under precautions. The DON explained that she monitored the staff by making walking rounds and monitoring the Quarantine unit and had not identified an issue with the Social Worker. On 08/19/22 at 4:30 PM an interview was conducted with the Administrator who explained that the staff should follow the Special Droplet Contact Precautions posted on the Residents' doors and that the entire facility staff would be reeducated on the Infection Control Process. 3. On 08/17/22 at 3:05 PM an observation was made of Nurse Aide (NA) #1 donning a gown and gloves (she already wore a KN95 mask and goggles) before she entered Resident #10's room (150) who was admitted to the facility on [DATE] and was partially vaccinated. Posted on the Resident's door was a Special Droplet Contact Precautions sign. The NA exited the room without the gown and gloves but still wearing the mask and goggles then used hand sanitizer as she walked up the hall. On 03/17/22 at 3:10 PM an interview was conducted with Nurse Aide (NA) #1 who explained that she removed her gown and gloves and washed her hands inside the Resident's room after she provide incontinent care and before she exited the room. The NA continued to explain that she did not change her mask and goggles because she always wore her personal KN95 mask and goggles as did all the other staff. The NA stated she could have put a facility N95 mask and eye protection on then changed back to her personal PPE after she came out of the room. The NA stated she attended an infection control inservice the week prior and was trained to don the N95 mask and goggles provided by the facility. The NA opened the PPE tower next to the Resident's room and acknowledged there was plenty PPE available for use. On 08/18/22 at 3:35 PM an interview was conducted with the Director of Nursing (DON) who also served as the Infection Control Nurse (ICN). The DON explained that approximately a month ago she provided infection control education for both shifts that included donning/doffing PPE, the different types of Precautions, and the Quarantine unit. The DON continued to explain that the staff were supposed to remove the gowns and gloves and wash their hands while in the rooms then replace their masks and eye protection after they exit the rooms. She stated the staff could wear their personal PPE as long as it was not the PPE worn in the rooms of residents under precautions. The DON explained that she monitored the staff by making walking rounds and monitoring the Quarantine unit and had not identified an issue with the Social Worker. On 08/19/22 at 4:30 PM an interview was conducted with the Administrator who explained that the staff should follow the Special Droplet Contact Precautions posted on the Residents' doors and that the entire facility staff would be reeducated on the Infection Control Process.