STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. Building B. Wing	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hertford Rehabilitation and Healthcare Center	1300 Don Juan Road Hertford, NC 27944

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on observations and staff interviews the facility failed to maintain a clean-living environment and maintain resident furniture in good repair for 5 of 13 rooms (room [ROOM NUMBER], 308, 310, 303, 306) reviewed for environment. Findings included: Observation of hall 300 and hall 400 revealed the following. a. room [ROOM NUMBER] was observed on 1-9-23 at 3:05pm. The observation showed the residents over the bed table had been broken in one corner allowing the sharp edge of the plastic cover exposed, the ceiling vent in the bathroom was hanging from the ceiling covered with dust, the windowsill had large areas of a brown substance and there was a brown/orange substance on the floor next to the bed. During a second observation of room [ROOM NUMBER] occurred on 1-12-23 at 9:09am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director, the observation revealed the residents over the bed table had been broken in one corner allowing the sharp edge of the plastic cover exposed, the ceiling vent in the bathroom was hanging from the ceiling covered with dust, the window sill had large areas of a brown substance and there was a brown/orange substance on the floor next to the bed. The Maintenance Director was interviewed on 1-12-23 at 10:05am. He explained he had ordered new over the bed tables and had replaced some but was not aware of room [ROOM NUMBER]'s table. He stated he would have the table replaced. He also stated he was unaware of the bathroom vent dislodging from the ceiling. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator stated the substance on the floor and windowsill was from the resident's tube feeding. He explained he was aware of the cleaning issues but said he felt the changes he had made had not been able to make an impact. b. room [ROOM NUMBER] was observed on 1-9-23 at 10:33am. The observation showed a brown and yellow substance on the wall next to the door, the wall heating and cooling unit had white and black particles in the vent and the light fixture above the resident's bed had a reddish/brown substance around the frame of the fixture and the popcorn ceiling was peeling off. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second observation of room [ROOM NUMBER] occurred on 1-12-23 at 9:00am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director. The observation showed a brown and yellow substance on the wall next to the door, the wall heating and cooling unit had white and black particles in the vent and the light fixture above the resident's bed had a reddish/brown substance around the frame of the fixture and the popcorn ceiling was peeling off. The Maintenance Director was interviewed on 1-12-23 at 10:05. He stated he was responsible for cleaning the wall heating and air vents. The Maintenance Director stated he tried to do this monthly but said he had been preoccupied with other issues in the facility. He also stated the popcorn ceiling peeling off was a new problem and he would address the issue. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator stated the housekeepers assigned to the room should be cleaning any substances off the walls and light fixtures. c. During an observation of room [ROOM NUMBER] on 1-9-23 at 10:45am, the observation revealed a brown substance on the light switch by the door, the wall heating and air unit had white, brown and black particles in the vent and the light fixture above the resident bed had a reddish-brown substance around the frame of the fixture. A second observation of room [ROOM NUMBER] occurred on 1-12-23 at 9:05am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director. The observation revealed a brown substance on the light switch by the door, the wall heating and air unit had white, brown, and black particles in the vent and the light fixture above the resident bed had a reddish-brown substance around the frame of the fixture. The Maintenance Director was interviewed on 1-12-23 at 10:05am. He stated he was responsible for cleaning the wall heating and air vents. The Maintenance Director stated he tried to do this monthly but said he had been preoccupied with other issues in the facility. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator stated the housekeepers assigned to the room should be cleaning any substances off light switches and light fixtures. d. room [ROOM NUMBER] was observed on 1-9-23 at 3:00pm. The observation revealed a brown substance on the floor next to the bed and the ceiling light cover in the bathroom contained a black residue and the end cap of the cover was coming off. A second observation was made on 1-12-23 at 8:45am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director. The second observation revealed a brown substance on the floor next to the bed and the ceiling light cover in the bathroom contained a black residue and the end cap of the cover was coming off. The Maintenance Director was interviewed on 1-12-23 at 10:05am. The Maintenance Director explained he made room rounds weekly and was not aware of room [ROOM NUMBER]'s bathroom light fixture. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator explained the facility did not have an Environmental Manager because the facility had changed services. He also stated he made room rounds almost daily and had been aware of the issue in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. An observation of room [ROOM NUMBER] occurred on 1-9-23 at 10:30am. The observation revealed a brown substance smeared on the door frame. During a second observation on 1-12-23 at 8:49am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director, the observation revealed a brown substance smeared on the door frame. An interview with the Administrator occurred on 1-12-23 at 10:11am. The Administrator stated housekeeping was responsible for ensuring resident door frames were clean.

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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 - Few	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** 38920 Based on observations, record reviews and resident and staff interviews the facility failed to provide nail care to residents who needed extensive assistance and/or dependent for Activities of Daily Living (ADL) care for 2 of 3 residents (Resident #47 and Resident #27) and failed to rinse soap off a resident's skin during a bed bath for 1 of 3 resident (Resident #67) reviewed for ADL care. Findings included: 1. Resident #47 was admitted to the facility on [DATE] with multiple diagnoses that included hemiplegia and hemiparesis affecting right dominant side and diabetes. Resident #47's care plan dated 12-13-22 revealed a goal that Resident #47 would improve current level of functioning in ADLs. The interventions for the goal were check nail length, trim and clean on bath day. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #47 was cognitively intact and required total assistance with one person for bathing and personal hygiene. Resident #47 was observed and interviewed on 1-9-23 at 10:55am. Resident #47 was observed to have approximately half inch fingernails that had a black substance caked underneath. The resident stated he did not like having long dirty fingernails and explained he had asked staff to cut them several times but could not remember who he asked. An observation of Resident #47 occurred on 1-11-23 at 8:05am. The observation revealed the resident continued to have long fingernails with a black substance caked underneath. Nursing Assistant (NA) #4 was interviewed on 1-11-23 at 8:20am. The NA stated she had recently been assigned to Resident #47 but could not remember the day. She stated she had observed Resident #47's fingernails being long and dirty and explained she could not cut them because the resident was diabetic and only a nurse could cut his nails. NA #4 stated she did not inform the nurse on duty that Resident #47's nails needed cut. An interview with NA #3 occurred on 1-11-23 at 8:25am. NA #3 stated she was assigned to Resident #47 yesterday (1-10-23). She said the resident had requested his fingernails be cut and stated she had observed the resident's fingernails to be long and dirty. NA #3 explained she was not allowed to cut Resident #47's fingernails because he was a diabetic and only a nurse could cut them. She stated she did not inform the nurse of Resident #47's request to have his fingernails cut because I forgot to tell her. During an interview with the [NAME] President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated the NAs could cut Resident #47's fingernails and should have been cut when he requested. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated the NAs need to be trained and knowledgeable in resident nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #27 was admitted to the facility on [DATE] with multiple diagnoses that included heart failure, vascular dementia, and chronic obstructive pulmonary disease. Resident #27's care plan dated 9-12-22 revealed a goal that he would improve his current level of functioning in Activities of Daily Living (ADL). The interventions for the goal were Resident #27 required extensive assistance with one person for bathing. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was moderately cognitively impaired and required extensive assistance with one person for personal hygiene. Resident #27 was observed and interviewed on 1-9-23 at 11:00am. Resident #27's fingernails were observed to be approximately half an inch long. The resident stated he did not like to have his fingernails long and had asked staff to cut them but could not remember who he asked. An observation was made on 1-11-23 at 8:05am of Resident #27. The observation revealed Resident #27's fingernails remained long. Nursing Assistant (NA) #4 was interviewed on 1-11-23 at 8:20am. NA #4 stated she was assigned to Resident #27 today (1-11-23) and had observed his fingernails to be long. She stated she could not remember if the resident had asked for his fingernails to be cut or if she offered to cut his fingernails but said she had not cut his fingernails. An interview with NA #3 occurred on 1-11-23 at 8:25am. NA #3 stated she had been assigned to Resident #27 yesterday (1-10-23) and had observed his fingernails being long. She also stated Resident #27 had requested for his fingernails to be cut but said she did not cut them because I did not have time. During an interview with the [NAME] President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated the NAs could cut Resident #47's fingernails and should have been cut when he requested. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated the NAs need to be trained and knowledgeable in resident nail care. 3. Resident #67 was admitted to the facility on [DATE] with multiple diagnoses that included nontraumatic intracranial hemorrhage, locked in state. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #67 was severely cognitively impaired and required total assistance with one person for bathing. Resident #67's care plan dated 12-30-22 revealed a goal that he would improve his level of functioning in Activity of Daily Living (ADL) care. The intervention for the goal was the resident was totally dependent on staff for bathing. An observation of ADL care for Resident #67 occurred on 1-10-23 at 11:43am with Nursing Assistant (NA) #3. The NA was observed to use a shampoo and body wash with the directions to rinse the soap off the resident. NA #3 was observed to soap the washcloth, clean the resident, and then take a towel to dry the resident without rinsing the soap off first. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA #3 was interviewed on 1-10-23 at 11:48am. The NA stated she always used the shampoo and body wash to bath Resident #67 and stated she was unaware the soap she was using needed to be rinsed off Resident #67 before she dried the resident. During an interview with the [NAME] President (VP) of Clinical Services on 1-11-23 at 4:415pm, the VP of Clinical Services stated the NA should have read the directions and rinsed the soap off Resident #67 as directed. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated the NAs need to be trained and knowledgeable in the bathing process.

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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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on observations, record review, staff, Wound Care Physician, and Medical Director interviews, the facility failed to provide ongoing skin assessments, monitor consistently, and ensure treatments and interventions were implemented to prevent pressure ulcer development and worsening for a resident at risk for pressure ulcers who was admitted to the facility without pressure ulcers. On 10/02/22 Resident #67 was identified with a stage 2 pressure ulcer on his sacrum that worsened to a stage 4 pressure ulcer on 11/9/22. On 12/25/22 Resident #67 was diagnosed with osteomyelitis on admission to the hospital. In addition, the facility had a lower level of deficient practice when the facility failed to provide ongoing skin assessments, consistent wound monitoring, and to implement interventions of a low air-loss mattress and turning and repositioning as recommended by the wound care physician for Resident #5. This deficient practice affected 2 of 3 residents reviewed for pressure ulcers (Resident #67 and #5). Immediate Jeopardy began on 11/09/22 when the facility failed to assess and identify a stage 4 sacral pressure ulcer for Resident #67. The immediate jeopardy was removed on 1/28/23 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the education and the monitoring systems put in place are effective and to address deficient practice for Resident #5. Findings included: 1. Resident #67 was admitted to the facility on [DATE] with diagnoses which included traumatic brain dysfunction and respiratory failure. The head-to-toe skin assessment dated [DATE] at 8:28 AM revealed Resident #67 had no pressure ulcers present on the 7/11/22 admission. Resident #67's care plan initiated on 7/13/22 had a focus for potential impairment to skin integrity related to fragile skin, immobility, and incontinence. The interventions included weekly skin assessments and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. A pressure sore scale for predicting pressure sore risk dated 7/18/22 at 4:28 PM assessed the resident was at high risk. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #67 had severe cognitive impairment and was totally dependent on staff for all activities of daily living including bed mobility. The assessment noted no pressure ulcers, always incontinent of bowel and bladder, was on a scheduled pain medication regimen, received no as needed pain medication, had no weight gain or loss and received 100% nutrition through a feeding tube. The resident had no behaviors or refusal of care. He was coded to have a pressure reducing device for bed. The weekly skin assessments from 7/11/22 through 8/30/22 revealed no pressure ulcers present. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The weekly skin assessment dated [DATE] revealed a stage 2 neck pressure ulcer which was treated and resolved on 9/28/22. The weekly skin assessment completed by Nurse #10 dated 9/28/22 revealed moisture associated skin damage to the sacrum. The September 2022 Treatment Administration Record (TAR) revealed the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks three times per day. The weekly skin assessment completed by Nurse #2 dated 10/02/22 revealed a stage 2 pressure ulcer to the sacrum. An interview on 1/27/23 at 2:04 PM with Nurse #2 revealed she was not currently employed at the facility but had been assigned to provide care for Resident #67 three nights per week for the three months she worked at the facility. She stated that wound care treatments were completed during the day and did not remember completing the weekly skin assessment. The care plan was not updated when the sacral pressure ulcer was identified. The quarterly MDS dated [DATE] revealed Resident #67 had severe cognitive impairment and was totally dependent on staff for all activities of daily living including bed mobility. The assessment noted one unstageable pressure ulcer which was not present on admission, always incontinent of bowel and bladder, was not on a scheduled pain medication regimen, received no as needed pain medication, had no weight gain or loss and received 100% nutrition through a feeding tube. The resident had no behaviors or refusal of care. He was coded to have a pressure reducing device for bed, received pressure ulcer/injury care, and application of ointments/medications to other than feet. The October 2022 TAR revealed a continuation of the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks three times per day. An additional treatment order dated 10/14/22 read in part for Collagenase (used to remove dead tissue) ointment applied to sacrum every day. This treatment was not signed as completed on 10/19/22 and 10/22/22. An interview on 1/27/23 at 8:52 AM with Nurse #9 revealed she had obtained the order dated 10/14/22 for Collagenase. She stated she did not remember if the physician assessed the sacral wound or if she called him. She stated she observed the wound when assisting the Nursing Assistant (NA) with resident care on 10/14/22. Nurse #9 also stated she did not complete wound measurements or notify management about this wound. She stated that if she completed the wound care treatments, she signed the TAR. There were no weekly skin checks or pressure ulcer assessment notes after 10/02/22 until 11/09/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #67 was first assessed and treated by the Wound Care Physician for his sacral pressure ulcer on 11/09/22. His wound evaluation and management summary dated 11/09/22 read, in part, that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 6.5 centimeters (cm) by 5.0 cm by 0.1 cm. The ulcer had moderate serous exudate with 80% necrotic tissue and 20% granulation tissue. His ulcer detail note read, in part, that the resident was seen for initial evaluation and management of recent development of unstageable necrosis pressure injury of the sacrum. His plan of care recommendations included to off-load wound, turn side to side and front to back in bed every 1-2 hours if able, and a low air-loss mattress. His dressing treatment plan recommendations were for an absorbent, antimicrobial dressing applied daily for 30 days and Collagenase ointment applied daily for 30 days. Resident #67's wound evaluation and management summary dated 11/16/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.5 cm. The ulcer had moderate serous exudate with 60% necrotic tissue, 30% slough, and 10% granulation tissue. Resident #67's wound evaluation and management summary dated 11/23/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.9 cm. The ulcer had moderate serous exudate with 70% necrotic tissue, and 30% slough. Resident #67's wound evaluation and management summary dated 11/30/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.8 cm. The ulcer had moderate serous exudate with 20% necrotic tissue, 50% slough, and 30% granulation tissue. Resident #67's wound evaluation and management summary dated 12/07/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.8 cm. The ulcer had moderate serous exudate with 70% necrotic tissue and 30% slough. Resident #67's wound evaluation and management summary dated 12/14/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.9 cm. The ulcer had moderate serous exudate with 60% necrotic tissue and 40% slough. Resident #67's wound evaluation and management summary dated 12/21/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.9 cm with undermining of 4.3 cm at 3 o'clock. There was a deep tissue injury (DTI) noted within the wound bed area. The ulcer had moderate serous exudate with 60% necrotic tissue, 30% slough, and 10% granulation tissue. An interview with the Wound Care Physician on 1/11/23 at 3:00 PM revealed he made recommendations in his wound care notes. He stated he had recommended a low air-loss mattress for Resident #67 on his 11/09/22 recommendations. He also stated that a low air-loss mattress and turning and repositioning were vital to wound healing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Another interview with the Wound Care Physician on 1/27/23 at 11:44 AM revealed he was consulted by the facility to see Resident #67. He stated he could not say how the resident's wound developed, but confirmed it was a stage 4 sacral pressure ulcer when he initially assessed it on 11/09/22. He stated the resident was at high risk for wound development due to his medical comorbidities. The Wound Care Physician stated that he followed the resident weekly and when he saw him on 12/21/22 he noted no signs or symptoms of infection, but the resident had a high biofilm (thin, slimy film of bacteria that adheres to a surface) and necrotic burden (dead tissue that is a physical barrier and is a medium for bacterial growth), so he was at high risk of developing an osteomyelitis infection. The November 2022 TAR revealed a continuation of the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks three times per day. The treatment order dated 10/14/22 for Collagenase to the sacrum was discontinued on 11/09/22. This treatment was not signed as completed on 11/2/22 and 11/4/22. The November 2022 TAR also had an order dated 11/09/22 for Collagenase ointment with an absorbent, antimicrobial dressing to be applied every day. This order was discontinued on 11/16/22. This treatment was not signed as completed on 11/11/22. The November 2022 TAR had an order dated 11/16/22 for Collagenase ointment with an absorbent, antimicrobial dressing to be applied every day. This treatment was not signed as completed on 11/18/22, 11/23/22, and 11/26/22. Resident #67's care plan was updated on 11/29/22 with an additional focus area notation that the resident had a pressure wound to inner buttocks. The goals and interventions were not updated. The weekly skin assessment completed by Nurse #11 dated 12/07/22 revealed a stage 4 pressure ulcer to the sacrum. The wound measurements were 7.0 cm x 5.0 cm x 1.8 cm. An interview with the Nurse #11 on 1/27/23 at 11:23 AM revealed she was an agency nurse and had worked at the facility for a couple of months mostly as the wound care nurse. She stated she rarely saw the resident in a different position and did not feel he was turned or repositioned as he should have been to prevent his pressure ulcers from getting worse or not healing. She stated the hall nurse was responsible for completing the residents' weekly skin assessments. She also stated that they were responsible for completing the residents' wound care treatments if there was no wound care nurse. The Wound Care Physician's wound evaluation and management summary dated 12/21/22 did not indicate concerns about infection and noted moderate serous drainage. The wound was debrided to remove necrotic tissue and biofilm and health bleeding tissue was observed. The wound measurements were 7.0 cm x 5.0 cm x 1.9 cm. The December 2022 TAR revealed a continuation of the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks every shift which was three times per day. This treatment order was discontinued on 12/30/22. The December 2022 TAR had an order dated 11/16/22 for Collagenase ointment with an absorbent, antimicrobial dressing to be applied every day. This order was discontinued on 12/20.22. This treatment was not signed as completed on 12/01/22, 12/09/22, 12/13/22, and 12/17/22. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The December 2022 TAR had an order dated 12/20/22 for Collagenase ointment and collagen powder with an absorbent, antimicrobial dressing to be applied every day. This order was discontinued on 12/21/22. The December 2022 TAR had an order dated 12/21/22 for Collagenase ointment and collagen powder and to pack the wound with wound cleanser moistened gauze with an absorbent, antimicrobial dressing every day. This order was discontinued on 12/30/22. This treatment was not signed as completed on 12/23/22. Review of nurses' progress note completed by Nurse #12 dated 12/22/22 revealed Resident #67 tested positive for COVID. Review of nurses' progress note completed by Nurse #2 dated 12/25/22 revealed the resident was sent to the hospital for fever and respiratory distress. Resident #67's care plan initiated on 12/30/22 had a focus for multiple pressure injuries related to incontinence and decreased mobility and was at risk for worsening of wounds and additional breakdown. The interventions included to reposition and/or turn at frequent intervals to provide pressure relief and complete a full body check weekly and document. Review of Resident #67's hospital discharge summary dated 1/05/23 included admission diagnoses of Covid pneumonia and stage 4 decubitus ulcer with osteomyelitis. He was treated with intravenous (IV) antibiotics with a discharge medication list to continue two antibiotics for 32 days. Resident #67's admission skin assessment dated [DATE] indicated he had a stage 4 sacrum pressure ulcer which measured 6.4 cm by 4.0 cm by 2.1 cm. Multiple observations were made on 1/10/23 at 10:00 AM, 11:15 AM, 12:27 PM and 1:09 PM. Resident #67 was observed to lie in the same position with the head of bed at about 45 degrees, face to the right, lying on his back, pillow under left arm, pillow under right side arm/side, feet wearing protective boots, and legs straight. The resident was not observed to make any independent movements and was not interviewable. The resident was observed to be on a low air-loss mattress. An interview with Nursing Assistant (NA) #3 on 1/10/23 at 2:13 PM revealed she was assigned to provide care for Resident #67. She also revealed she was scheduled to work from 7:00 AM until 3:00 PM. She stated she had turned him one time that day during his bath right before lunch. She stated that the resident did not get turned every 2 hours today because she was trying to give other residents their baths. She stated she was familiar with the resident, and she knew he was supposed to be turned every 2 hours. An interview with NA #6 on 1/26/23 at 3:11 PM revealed she was regularly assigned to provide care for Resident #67. She stated she did not turn him completely on his side but used pillows or wedges under his buttocks to reposition him. She also stated she turned him as often as possible but was unable to always turn him every 2 hours. An interview with NA #4 on 1/27/23 at 9:51 AM revealed she had been assigned to provide care for Resident #67 occasionally. She stated that she tried to turn and reposition the resident every 2 hours but that was not always possible if she got busy. (continued on next page)

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	345262	A. Building B. Wing	01/31/2023

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Nurse #8 on 1/10/23 at 1:36 PM revealed she was the assigned nurse for Resident #67. She stated she was his assigned nurse frequently but had only been employed at the facility a short time. She did not provide wound care as there was a wound care nurse. She stated she had never seen him fully turned from one side to the other. She stated she saw pillows placed under one hip then the other to offload pressure on the sacral wound. She stated that he coughed more if turned onto his side. An interview with Nurse #10 on 1/27/23 at 12:02 PM revealed she had been employed at the facility as the wound care nurse for approximately 1 year and no longer worked at the facility. She stated when she first started working at the facility, she often worked 7 days per week, but then worked 3-5 days per week. She stated she completed weekly assessments and provided wound care treatments to Resident #67. She stated that if the TAR wasn't signed, then the treatment had not been done. She stated when she was the wound care nurse, she completed the weekly skin assessments and wound assessments. A wound care observation was completed with Nurse #11 and the Wound Care Physician on 1/11/23 at 3:17 PM revealed Resident #67's sacrum pressure ulcer was 6.5 cm (centimeters) x 4.4 cm x 1.9 cm with moderate serosanguinous exudate. The wound had 3.4 cm undermining (when the wound edges become eroded and a pocket forms beneath the wound edge) at the 3 o'clock position and contained 40% slough and 60% granulation. An interview with the Medical Director on 1/12/23 at 11:11 AM revealed he believed lack of turning and repositioning could contribute to pressure ulcer decline. He also stated he relied on the facility to ensure the wound physician recommendations in their notes were completed. A further interview with the Medical Director on 1/27/23 at 7:58 PM, he revealed he had seen and assessed Resident #67's sacral wound when it was a stage 2 but did not specify a date. He stated that the resident had multiple comorbidities which included his cerebrovascular disease, chronic respiratory failure, and tube feeding nutrition but that the lack of care he received played a part in his sacral wound development. He specified the lack of care as the resident not being turned or repositioned as frequently as necessary to prevent the sacral pressure ulcer from developing and worsening and noted that the resident did not have a pressure ulcer on admission. He also felt that weekly skin checks were important. An interview with the [NAME] President of Clinical Operations on 1/12/23 at 1:45 PM revealed the facility should adhere to the standards of wound management which included turning and repositioning. She also revealed that Resident #67 had significant comorbidities for pressure ulcer development. The Administrator was notified of the immediate jeopardy on 1/27/23 at 1:10 PM. The facility provided the following plan for immediate jeopardy removal: - Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Inconsistent nursing leadership led to the compliance failure. The [NAME] President of Quality Assurance completed this root cause analysis on 1/12/2023. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #67's skin assessment was completed on 01/27/2023 by the Unit Manager. The braden scale assessment was completed on 01/13/2023 by staff Registered Nurse and scores a 10, which indicates at risk for skin breakdown. Skin assessment shows sacrum stage IV and left heel deep tissue injury. Orders were entered for weekly skin assessments and weekly pressure wound observations, that were not previously in place. Assessments were scheduled for weekly skin and weekly pressure wound observations, that were not previously in place. Turning and repositioning as needed, not previously in place, was added to plan of care tasks, to be signed by Nursing Assistants, indicating the completion of turning and repositioning task occurred each shift. Resident continues on an air mattress. These updates were entered by the Director of Nursing 1/20-1/27/23. Interventions are in place to address pressure ulcers for Resident #67. - Heel protector boots-1/19/23 ordered, Occupational Therapy 1/5/23, turning and positioning, as needed 01/20/23, air mattress- 11/9/22, the facilty's wound care provider's recommendations were reviewed entered as physician's orders on 01/26/23, by the Director of Nursing. Residents with a high risk braden score, were audited on 01/27/2023 by the Director of Nursing. Interventions will be reviewed and implemented, as appropriate. No new residents were identified. Braden assessments were audited for residents triggering to be at risk for skin breakdown. Plans of care will be reviewed for those residents that trigger at risk, by the Director of Nursing, Unit Manager and MDS nurse on 01/27/23, to ensure interventions are current and appropriate. - 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: Nurses are being educated by the Unit Manager, regarding documentation of skin assessments, and braden assessments upon admission, with ongoing weekly skin assessments, weekly pressure wound observations, and quarterly braden assessments. Nurses not currently available for education, will receive education by the Unit Manager or Wound Care Nurse prior to assuming their next shift assignment. Nursing education was completed on 1/27/23, and included staff nurses and agency nurses, that are on our current schedules. New hires will receive this education by the Nursing Management team, as part of their nursing orientation. The wound nurse is responsible for the wound management, Monday- Friday, and a nurse will be scheduled on the weekends, for wound care continuity. Should the wound nurse be absent, then the Unit Manager will assume responsibility for wound care. A staff nurse has been identified as the primary wound care nurse effective January 27, 2023 and has been enrolled in a wound care certification program. Date of alleged IJ removal: 01/28/2023 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The credible allegation of immediate jeopardy removal was validated by onsite verification on 1/31/23. Interviews conducted with nursing staff revealed they had attended training on Wound Management- Skin and Wound Protocol. The education included Braden scale, weekly skin review which was to be completed by the licensed nurse for each resident weekly. Weekly pressure wound observation tool- to be completed by clinical managers/designee when the weekly assessment is not completed by the Wound NP. Weekly non-pressure wound observation tool -for diabetic ulcers, arterial or vascular ulcers, surgical wound, excoriations, lacerations, abrasions, bruises , or skin tears- to be completed weekly by Clinical Manager/designee if the Wound NP did not access the area. The education also included steps to take if there were changes to the resident's skin integrity or wound outside the scheduled observations. Inservice forms were reviewed and indicated the dates, topics discussed, and the trainer, and included attending staff signatures. A review of the weekly wound observation dated 1/25/23 revealed the resident was seen by the facility's wound clinic and new orders provided. A review of the physician's orders for the month of January 2023 revealed that new orders and recommendations were included on the MAR. A review of the plan of care NA task list report last updated 1/27/23 included skin care, positioning, and skin integrity. A review of the Braden scale audit and verification log revealed 100 % of the residents were reviewed on 1/27/23. The facility had appointed a nurse as Wound Nurse Monday thru Friday and the individual has been signed up for a 2-part wound care certification program effective 1/27/23. An Interview conducted with new wound nurse on 1/31/23 revealed that his schedule would be from 11AM-7PM Monday through Friday. The wound nurse stated when he was not present, there was a backup nurse or another agency nurse that would complete the treatments/wounds. He stated his job entailed being responsible for all the treatments, weekly skin checks, weekly wound assessments, and Braden scales. An interview was conducted with the Director of Nursing (DON) on 1/31/23 at 3:00 PM. The DON stated that the wound care nurse would be responsible for wound care management documentation and validation. An observation of Resident #67 on 1/31/23 at 12:35 PM revealed that he was wearing heel protector boots and a pressure relieving mattress was in place. The facility's Immediate Jeopardy removal date of 1/28/23 was validated. 2. Resident #5 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident and seizure disorder. The baseline care plan dated 8/29/22 had a focus for pressure ulcers present upon admission 8/26/22 and is at risk for further pressure injury development. Resident #5 was initially evaluated and treated by the Wound Care Physician on 8/31/22 for three deep tissue injuries (DTI) and one unstageable sacral pressure ulcer. The Wound Care Physician's evaluation and management summary dated 8/31/22 included recommendations to off-load wound, turn side to side and front to back in bed every 1-2 hours if able, and a low air-loss mattress. Review of Resident #5's electronic medical record census indicated he was sent to the hospital on 9/01/22 and returned to the facility on [DATE]. Review of Resident #5's head to toe skin check dated 9/14/22 revealed the resident returned to the facility with an additional wound and changes to the previous wounds. The Wound Care Physician's evaluation and management summary dated 9/21/22 had additional wound detail which read in part that the resident returned to the facility after hospitalization for sepsis due to presumed endocarditis complicated by wound infection and strong suspicion for osteomyelitis underlying stage 4 pressure wound of the sacrum. Resident's overall prognosis is poor. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There were no weekly skin checks or pressure ulcer assessment notes from 10/06/22 until 10/26/22. Resident #5's quarterly MDS dated [DATE] revealed he had 1 stage 3 pressure ulcer which was present on admission. He had 3 stage 4 pressure ulcers, 2 of which were present on admission. He had 2 unstageable pressure ulcers, none of which were present on admission. He also had 8 unstageable suspected deep tissue injury pressure ulcers, 1 of which was present on admission. Review of Resident #5's head to toe skin check dated 12/30/22 revealed he had eleven pressure areas. The Wound Care Physician's Wound Evaluation and Management Summary note dated 1/04/23 for Resident #5 included staging, measurements, notations of exudate, etiology and the treatment plan for each wound. The summary included that the resident returned to the facility after hospitalization for sepsis likely secondary to urinary tract infection/possible aspiration pneumonia complicated by heart attack likely secondary to sepsis/acute on chronic anemia, acute hypoxic respiratory failure likely secondary to aspiration pneumonitis and acute deep vein thrombosis (DVT) of left subclavian vein. As such, resident has returned to facility with deterioration in surface area and/or depth, and/or increase DTI/slough/necrosis in several wound. Multiple observations were made on 1/10/23 at 10:02 AM, 12:27 PM and 1:09 PM. Resident #5 was observed lying in the same position with the head of bed about 30 degrees, facing upright, lying on his back, arms crossed over lower body, towel under left arm, legs contracted with knees bent. The resident was not interviewable. The was no low air-mattress observed on the resident's bed. An interview with Nursing Aide (NA) #3 on 1/10/23 at 2:13 PM revealed she was assigned to provide care for Resident #5. She stated she had turned him one time that day during his bath right before lunch. She stated that the resident did not get turned every 2 hours today because she was trying to give other residents their baths. She stated she was familiar with the resident, and she knew he was supposed to be turned at least every 2 hours. An interview with Nurse #8 on 1/10/23 at 1:36 PM revealed she was assigned to the hall for Resident #5. She did not provide wound care as there was a wound care nurse. She stated he did not like to be moved and she did not know if the physician was aware of this. She confirmed that Resident #5 did not have a low air-loss mattress and stated his low air-loss mattress was on order and did not know the status. An interview with the Supply Clerk on 1/11/23 at 1:59 PM revealed she ordered a low air-loss mattress when she received a physician's order. She stated she had received an order today for a low air-loss mattress. An interview with the Wound Care Physician on 1/11/23 at 3:00 PM revealed he made recommendations in his wound care notes. He stated he had recommended a low air-loss mattress for Resident #5 and did not know why he did not have one at this time. He also stated that a low air-loss mattress and turning and repositioning were vital to wound healing. He also stated that the resident had multiple medical comorbidities and contractures which contributed to his pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the Medical Director on 1/12/23 at 11:11 AM revealed he relied on the staff to obtain the low air-loss mattress. He also revealed that Resident #5 had contractures and general decline which contributed to his pressure ulcers. An interview with the [NAME] President of Clinical Operations on 1/12/23 at 1:45 PM revealed the facility should adhere to the standards of wound management which includes turning and repositioning. She also revealed that Resident #5 had significant comorbidities for pressure ulcer development.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on observation, staff and Physician interview the facility failed to ensure emergency equipment was present at the bedside for residents with tracheostomies. This occurred for 2 of 2 residents (Resident #67 and Resident #57) reviewed for tracheostomy care. Findings included: a. Resident #67 was admitted to the facility on [DATE] with multiple diagnoses that included tracheostomy status. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #67 was severely cognitively impaired and required oxygen, suctioning and tracheostomy. Resident #67's care plan dated 12-20-22 revealed a goal that Resident #67 will not have any signs or symptoms of infection. The interventions for the goal were keep extra tracheostomy tube and obturator (equipment used to insert a tracheostomy tube) at bedside. Observation of Resident #67 occurred on 1-9-23 at 3:00pm. The resident was observed laying in the bed with a tracheostomy. Observation of the resident room revealed there was no emergency equipment in the room to include tracheostomy tube/obturator. Another observation of Resident #67's room on 1-10-23 at 9:15am revealed no emergency equipment in the room to include tracheostomy tube/obturator. The facility's Medical Director was interviewed by telephone on 1-10-23 at 9:32am. The Medical Director stated Resident #67 should have emergency equipment present in his room that would include an extra tracheostomy tube and obturator. He also stated he was aware Resident #67 did not have any emergency equipment in his room and said he had asked staff to place the emergency equipment in Resident #67's room. During an interview with the [NAME] President (VP) of Clinical Services on 1-11-23 at 9:30am, the VP of Clinical Services stated the facility did not have a policy regarding tracheostomy care. She explained the facility had specific respiratory policies, but they did not include tracheostomy care. Resident #67's room was observed on 1-11-23 at 10:00am. The observation revealed no emergency equipment in the room to include tracheostomy tube/obturator. Nurse #1 was interviewed on 1-11-23 at 1:27pm. Nurse #1 stated she has been assigned to Resident #67. She said she had never seen emergency equipment in the resident room and explained if an emergency occurred with Resident #67's tracheostomy she would send the resident to the emergency room . During an interview with Nurse #5 on 1-11-23 at 1:37pm, the nurse stated she had been assigned to work with Resident #67. She explained she had never seen any emergency equipment in the resident room and was unaware a tracheostomy resident needed to have emergency equipment at their bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview occurred with Nurse #6 on 1-11-23 at 1:41pm. Nurse #6 stated she had been assigned to Resident #67 a while ago. She said she did not recall the resident having any emergency equipment in his room and was not aware a tracheostomy resident needed emergency equipment at their bed side. During an interview with the [NAME] President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated all tracheostomy residents should have emergency equipment at their bed side and said Resident #67 has had his emergency equipment placed at his bed side. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated appropriate equipment should be available for the level of care being provided. b. Resident #57 was admitted to the facility on [DATE] with multiple diagnoses that included tracheostomy status. Resident #57's care plan dated 10-5-22 revealed a goal that she would not develop any signs or symptoms of infection. The interventions for the goal were keep extra tracheostomy tube and obturator at bedside. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was severely cognitively impaired and required oxygen, suctioning and tracheostomy. Observation of Resident #57's room on 1-9-23 at 3:10pm revealed no emergency equipment such as a tracheostomy tube or obturator was present in her room. Another observation of Resident #57's room [ROOM NUMBER]-10-23 at 8:10am revealed no emergency equipment was present in her room. The facility's Medical Director was interviewed by telephone on 1-10-23 at 9:32am. The Medical Director stated Resident #57 should have emergency equipment present in her room that would include a n extra tracheostomy tube and obturator. He also stated he was aware Resident #57 did not have any emergency equipment in her room and said he had asked staff to place the emergency equipment in Resident #57's room. Resident #57's room was observed on 1-11-23 at 10:05am and revealed no emergency equipment was present in her room. Nurse #1 was interviewed on 1-11-23 at 1:27pm. Nurse #1 stated she has been assigned to Resident #57. She said she had never seen emergency equipment in the resident room and explained if an emergency occurred with Resident #57's tracheostomy she would send the resident to the emergency room . During an interview with Nurse #5 on 1-11-23 at 1:37pm, the nurse stated she had been assigned to work with Resident #57. She explained she had never seen any emergency equipment in the resident room and was unaware a tracheostomy resident needed to have emergency equipment at their bedside. An interview occurred with Nurse #6 on 1-11-23 at 1:41pm. Nurse #6 stated she had been assigned to Resident #57 a while ago. She said she did not recall the resident having any emergency equipment in her room and was not aware a tracheostomy resident needed emergency equipment at their bed side. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the [NAME] President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated all tracheostomy residents should have emergency equipment at their bed side and said Resident #57 has had her emergency equipment placed at her bed side.

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review and staff, and physician interviews the facility failed to obtain and administer Oxycodone/acetaminophen (a controlled substance medication ordered to treat pain) as ordered for a resident who was newly admitted to the facility with a recent fracture of the upper and lower left humerus (a long bone located in the upper arm between the shoulder joint and elbow joint). The resident was transferred to the Emergency Department (ED) for unmanaged pain on two occasions (12/24/22 and 12/30/22) where he was provided with Oxycodone/acetaminophen as ordered which was effective in relieving the resident's pain. The resident reported a pain level on 12/24/22 at an 8 out of 10 (with 10 representing the worst pain imaginable) and on 12/30/22 a 10 out of 10 and he expressed he felt like he was being hit with a hammer. This was for 1 of 1 residents reviewed for pain management. Findings included: Resident #66 was admitted to the facility on [DATE]. His active diagnoses included fracture of the upper and lower left humerus. The hospital discharge summary dated 12/22/22 revealed he was ordered Oxycodone/acetaminophen 5-325 milligrams (a medication which is a combination of oxycodone and acetaminophen) every 4 hours as needed for pain. Resident #66's admission note dated 12/22/22 completed by Nurse #1 revealed he was alert and oriented and admitted for a fracture to the left arm due to a fall. Resident #66 had bruising noted to arms and chest, left flank area. During an interview on 1/10/23 at 2:15 PM Nurse #1 stated Resident #66 was admitted late on 12/22/22 around 7:00 PM. This was when her shift ended and Unit Manager #1 the took over for her when he arrived at the facility. She concluded that all she did was write the admitting note and did not put the resident's orders into their electronic medical records system. She stated this facility did not allow orders to be entered until the resident physically arrived in the facility, so the unit manager put Resident #66's orders in. Resident #66's orders revealed on 12/22/22 he was ordered Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours for pain. Review of a text conversation between Physician #1 and Unit Manager #1 on 12/22/22 from 6:06 PM to 6:14 PM revealed the unit manager notified the physician via text message that Resident #66 had admitted from the hospital and the hospital had not sent any hard script for Resident #66's Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as needed. Unit Manager #1 faxed a hard script to be signed to Physician #1 and Physician #1 texted and indicated he would send the hard script to the pharmacy. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/10/23 at 2:39 PM Unit Manager #1 stated when Resident #66 arrived at the facility on 12/22/22 the first question the resident asked was if his pain medication had arrived at the facility yet. Unit Manager #1 explained to him that the medications had not been entered into their system yet, therefore the pharmacy had not filled any of his prescription at that time. He informed the resident that if there was a medication due for him, they had a backup system in the facility to pull the medication for him to cover the break between the hospital and arrival of the medications from the pharmacy to the facility. After speaking with the resident, the Unit Manager began to enter the resident's orders on their electronic records system. He noted Resident #66's order for Oxycodone/acetaminophen 5-325 milligrams required a hard script at their pharmacy since it was a controlled substance, and a hard script was not sent from the hospital. At that point, on 12/22/22, he texted the physician to explain the situation and informed him that they needed the hard script. The doctor sent the order to the pharmacy that evening. The Medication Administration Record (MAR) indicated no Oxycodone/acetaminophen was administered to Resident #66 on 12/22/22. Resident #66's baseline care plan dated 12/23/22 revealed he was care planned for pain. The interventions included to evaluate the effectiveness of pain interventions, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, and notify physician if interventions are unsuccessful or if current complaint is a change from past experience of pain. Review of a text conversation between Physician #1 and Unit Manager #1 on 12/23/22 from 4:35 PM to 5:34 PM revealed Unit Manager #1 again texted the physician regarding Resident #66's pain medication not yet being received. The resident was noted to be complaining of pain as well as the family complaining on his behalf. During an interview on 1/10/23 at 2:39 PM Unit Manager #1 stated on 12/23/22 he was made aware by Resident #66 that he had not received his pain medication. He then sent Physician #1 another text requesting the hard script for the pain medication for Resident #66. Resident #66's MAR for 12/23/22 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth on 12/23/22 at 4:51 PM and again at 10:30 PM. These medications were pulled from the facility emergency backup medicine supply machine. A nursing note dated 12/24/22 at 3:32 AM revealed Nurse #2 documented Resident #66 had complaints of pain in his left shoulder which he rated an 8 out of 10. Nurse #2 called the pharmacy for Oxycodone/acetaminophen 5-325 milligrams as the medication for Resident #66 from the facility emergency backup medicine supply machine had run out. Physician #1 was messaged for other options. The pharmacy told the nurse that the Oxycodone/acetaminophen was on the way. A nursing note dated 12/24/22 at 5:00 AM revealed Nurse #2 documented Resident #66 stated he wanted to go to the hospital because he was in pain and couldn't wait for his pain medication to arrive. He was sent to the emergency department. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hertford Rehabilitation and Healthcare Center	1300 Don Juan Road Hertford, NC 27944

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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 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/24/22, Resident #66 requested pain medication and she identified the Oxycodone/acetaminophen 5-325 milligrams had not arrived at the facility yet. She indicated when she informed Resident #66 that his pain medication had not arrived, the resident requested to be sent to the hospital for pain management as his pain level was 8 out of 10. She stated she sent him to the hospital as he requested for pain management. A nursing note dated 12/24/22 at 10:42 AM revealed Nurse #3 documented Resident #66 returned to facility around 9:15 AM. Resident #66 was alert and oriented with no signs or symptoms of distress and he was ambulatory in his room. The hospital sent 2 Oxycodone/acetaminophen 5-325 milligrams via emergency medical services. During an interview on 1/11/23 at 9:07 AM Nurse #3 stated Resident #66 had a blister pack of Oxycodone/acetaminophen 5-325 milligrams in the medication cart during her shift when he returned from the hospital on 12/24/22. She reported his pain medication was available and provided as needed per orders during her shift and his pain was under control at that time. During an interview on 1/10/23 at 9:45 AM Physician #1 stated Resident #66 was prescribed Oxycodone/acetaminophen 5-325 milligrams every 4 hours as needed for pain on admission to the facility. He indicated on 12/23/22 he was made aware by a nurse that Resident #66 did not have a hard script, there was no Oxycodone/acetaminophen in the building available for him, and they did not have an emergency kit to pull the medication from. Physician #1 sent the hard script to the pharmacy via fax on 12/23/22 which was a Friday. On the morning of 12/24/22 Physician #1 was notified that Resident #66 had not received his pain medication from the pharmacy and had been in enough pain that he requested to be sent to the hospital due to pain. He indicated the resident received his pain medication at the hospital and returned to the facility the same day. During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated the resident came to the facility on [DATE]. She verified there was an issue with obtaining a hard script for Oxycodone/acetaminophen which resulted in this medication not arriving from the pharmacy until 12/24/22. She indicated prior to the arrival of the Oxycodone/acetaminophen 5-325 milligrams from the pharmacy, in the early morning of 12/24/22 Resident #66 requested pain medication and was told the medication was on the way. Resident #66 requested to be sent to the hospital for pain management as his pain level was 8 out of 10. He was sent to the hospital and during the time he was at the hospital, a blister pack with 18 Oxycodone/acetaminophen arrived at the facility. When he returned from the hospital his pain was under control. Resident #66's MAR for December 2022 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth on the following dates and times: - 12/24/22 at 11:42 AM, 3:43 PM, and 9:13 PM - 12/25/22 at 4:30 AM, 3:55 PM, and 10:04 PM. - 12/26/22 at 3:03 AM, 8:26 AM, and 6:07 PM - 12/27/22 at 12:46 AM, 5:09 AM, 3:30 PM, and 8:23 PM (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 0697 Level of Harm - Actual harm Residents Affected - Some	- 12/28/22 at 1:20 AM, 5:30 AM, 9:31 AM, and 2:23 PM - 12/29/22 at 1:21 AM A nursing note dated 12/29/22 written at 7:43 PM as late entry for 12/29/22 at 10:00 AM revealed Nurse #4 documented Resident #66 was upset that his Oxycodone/acetaminophen 5-325 milligrams was not available at the time requested. Nurse #4 informed Resident #66 they were waiting on the delivery of medication from the pharmacy. As needed Acetaminophen was offered, however, Resident #66 refused. Resident #66's family member arrived at bedside around 10:00 AM and started demanding medication for the resident related to left shoulder pain. During an interview on 1/12/23 at 8:56 AM Nurse #4 stated on 12/29/22 she was informed during change of shift when she came to work that Resident #66's pain medication had run out, but the refill was expected that morning. Resident #66 requested pain medication at some point that morning, but she did not know what time it was. It was later in the morning she believed as therapy was coming to work with the resident, and he stated he would not do therapy without his pain medications. She offered him Acetaminophen which he refused. She indicated he was agitated which she stated was understandable as he indicated his pain was at a 10 out of 10. His medication did not arrive that morning, so the nurse requested the Director of Nursing's assistance to contact the physician and pharmacy. A nursing note dated 12/29/22 at 12:05 PM revealed the Director of Nursing documented Resident #66 had complaints of pain. Resident #66 was noted with no more narcotics in the medication cart or available in the facility emergency backup medicine supply machine. A phone call was made to Physician #1 with a request for a new order for Oxycodone/acetaminophen 10-325 milligrams as 2 tabs were available in the facility emergency backup medicine supply machine and would be available to dispense until his prescription refill arrived that evening. An order dated 12/29/22 revealed Resident #66 was ordered Oxycodone/acetaminophen 10-325 milligrams by mouth every 4 hours for pain. Resident #66's MAR revealed he received Oxycodone/acetaminophen 10-325 milligrams by mouth on 12/29/22 at 12:00 PM and 4:00 PM. Resident #66's Minimum Data Set assessment dated [DATE] revealed he was assessed as moderately cognitively impaired. His active diagnoses included unspecified fracture of upper and end of left humerus. He was assessed to have frequent pain that had not disrupted his sleep in the past five days but had, over the past 5 days, limited his day-to-day activities because of pain. The worst pain he had experienced in the past 5 days had been a 7 out of 10. He received an opioid 7 of the 7 day look back period. A progress note dated 12/30/22 at 12:38 AM revealed Nurse #2 documented Resident #66 had complaints of severe pain and he no longer had any Oxycodone/acetaminophen 5-325 milligram or 10-325 milligram tablets available in the facility. Resident #66 reported 10 out of 10 pain in left arm and shoulder and current pain management was insufficient at that time. Resident #66 requested to go to the hospital for pain management. A nursing note dated 12/30/22 at 3:48 AM revealed Nurse #2 documented Resident #66 arrived back in facility from the hospital with his pain under control. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	The medical record indicated Resident #66 discharged home on 12/30/22. During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/30/22, Resident #66 requested pain medication and she did not have any Oxycodone/acetaminophen 5-325 milligrams or 10-325 milligrams. She stated she informed the resident she had Acetaminophen and was going to seek other options with the physician as well, and the resident requested to be sent to the hospital for pain management again as his pain level was at a 10 out of 10 and he told her it felt like he was being hit with a hammer. She stated she sent the resident to the hospital and notified the physician. During an interview on 1/10/23 at 9:45 AM Physician #1 stated on 12/29/22 he was called by the Director of Nursing, and she informed him that his 18 Oxycodone/acetaminophen pills had run out. She informed him she had two 10-325 milligram Oxycodone/acetaminophen in the facility, and she requested an order to give the resident this dose of the Oxycodone/acetaminophen while waiting for the pharmacy to deliver the medication. He indicated around 3:00 AM on 12/30/22 a nurse called to inform him that Resident #66 was back in the emergency department due to pain because his Oxycodone/acetaminophen still had not arrived at the facility. Physician #1 reported he was working at the hospital that night and called the emergency department to discuss the resident and the emergency department gave the resident pain medication and sent him back to the facility. The resident was scheduled to discharge home that day and he did discharge home as planned. He stated it was not acceptable to let a resident go without his pain medication. During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated it was not acceptable for a resident to be in severe pain at the facility due to the lack of ordered pain medication in the facility. She revealed this was why they sent him to the hospital both times as there were no other options and his pain needed to be controlled in that moment.

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F 0755 Level of Harm - Actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review and staff, pharmacy, and physician interviews the facility failed to obtain Oxycodone/acetaminophen (a controlled substance medication ordered to treat pain) from their pharmacy for a resident who was newly admitted to the facility with a recent fracture of the upper and lower left humerus (a long bone located in the upper arm between the shoulder joint and elbow joint). The resident was transferred to the Emergency Department (ED) for unmanaged pain on two occasions (12/24/22 and 12/30/22) due to the facility not having Oxycodone/acetaminophen available to the resident in the facility. The resident reported a pain level on 12/24/22 at an 8 out of 10 (with 10 representing the worst pain imaginable) and on 12/30/22 a 10 out of 10 and he expressed he felt like he was being hit with a hammer. This was for 1 of 1 resident reviewed for pharmacy services. Findings included: Resident #66 was admitted to the facility on [DATE]. His active diagnoses included fracture of the upper and lower left humerus. The hospital discharge summary dated 12/22/22 revealed he was ordered Oxycodone/acetaminophen 5-325 milligrams (a medication which is a combination of oxycodone and acetaminophen) every 4 hours as needed for pain. Resident #66's admission note dated 12/22/22 completed by Nurse #1 revealed he was alert and oriented and admitted for a fracture to the left arm due to a fall. Resident #66 had bruising noted to arms and chest, left flank area. During an interview on 1/10/23 at 2:15 PM Nurse #1 stated Resident #66 was admitted late on 12/22/22 around 7:00 PM. This was when her shift ended and Unit Manager #1 the took over for her when he arrived at the facility. She concluded that all she did was write the admitting note and did not perform any assessments and did not put the resident's orders into their electronic medical records system. She stated this facility did not allow orders to be entered until the resident physically arrived in the facility, so the unit manager put Resident #66's orders in. The unit manager would take the orders and put them in their system to order the medications from their pharmacy which would arrive on the next day, and they would use their backup medication system to bridge the gap. Resident #66's physician orders revealed on 12/22/22 he was ordered Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours for pain. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/10/23 at 2:39 PM Unit Manager #1 stated when a new admission came into the facility, he waited until the resident arrived with his discharge summary from the hospital. He waited for the resident to arrive from the hospital and utilized the physical discharge summary because there was always a chance that the medication was changed last minute by the hospital. He stated he took the physical paperwork including the discharge summary provided by emergency medical services upon the resident's arrival. He further stated once he had the orders in the discharge summary, he entered the orders in and once they are saved the order is automatically sent to the pharmacy. He stated if they had a medication that was due but had not arrived from the pharmacy or if the resident was asking for an as needed medication which they were able to receive at that time, they would go to the facility emergency backup medicine supply machine system which was a large, locked emergency medications kit. He stated when Resident #66 arrived at the facility on 12/22/22 the first question the resident asked was if his pain medication had arrived at the facility yet. Unit Manager #1 explained to him that the medications had not been entered into their system yet, therefore the pharmacy had not filled any of his prescription at that time. He informed the resident that if there was a medication due for him, they had a backup system in the facility to pull the medication for him to cover the break between the hospital and arrival of the medications from the pharmacy to the facility. After speaking with the resident, the Unit Manager began to enter the resident's orders on their electronic records system. He noted Resident #66's order for Oxycodone/acetaminophen 5-325 milligrams required a hard script at their pharmacy since it was a controlled substance, and a hard script was not sent from the hospital. At that point, on 12/22/22, he texted the physician to explain the situation and informed him that they needed the hard script. The physician sent the order to the pharmacy that evening. Review of a text conversation between Physician #1 and Unit Manager #1 on 12/22/22 from 6:06 PM to 6:14 PM revealed the unit manager notified the physician via text message that Resident #66 had admitted from the hospital and the hospital had not sent any hard script for Resident #66's Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as needed. Unit Manager #1 faxed a hard script to be signed to Physician #1 and Physician #1 texted and indicated he would send the hard script to the pharmacy. The Medication Administration Record (MAR) indicated no Oxycodone/acetaminophen was administered to Resident #66 on 12/22/22 or on 12/23/22 until 4:51 PM. Review of a text conversation between Physician #1 and Unit Manager #1 on 12/23/22 from 4:35 PM to 5:34 PM revealed Unit Manager #1 again texted the physician regarding Resident #66's pain medication not yet being received. The pharmacy had told Unit Manager #1 they had not received the hard script for Oxycodone/acetaminophen, and the resident was complaining of pain. Unit Manager #1 requested the physician send the hard script to a pharmacy nearby for staff to pick up the medication quickly. The physician replied that he would send the script directly to the main pharmacy again and that there had not been a hard script on his fax machine that morning (faxed from Unit Manager #1 the evening prior). (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Some	During a follow-up interview on 1/10/23 at 2:39 PM Unit Manager #1 stated on 12/23/22 he was made aware by Resident #66 that he had not received his pain medication. He then sent Physician #1 another text requesting the hard script for the pain medication for Resident #66. He asked if this could be sent to a backup local pharmacy nearby to be picked up. Physician #1 asked him where the patient was and if someone had faxed him the hard script. The unit manager told the doctor he had faxed the hard script last night but could fax it to him again. The doctor physician said there wasn't a hard script on his fax machine that morning. Physician #1 sent the script directly to the pharmacy himself. Resident #66's MAR for 12/23/22 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth on 12/23/22 at 4:51 PM and again at 10:30 PM. These medications were pulled from the emergency backup medicine supply machine. A nursing note dated 12/24/22 at 3:32 AM revealed Nurse #2 documented Resident #66 had complaints of pain in his left shoulder which he rated an 8 out of 10. Nurse #2 called the pharmacy for Oxycodone/acetaminophen 5-325 milligrams as the medication for Resident #66 from the facility emergency backup medicine supply machine had run out. Physician #1 was messaged for other options. The pharmacy told the nurse that the Oxycodone/acetaminophen was on the way. A nursing note dated 12/24/22 at 5:00 AM revealed Nurse #2 documented Resident #66 stated he wanted to go to the hospital because he was in pain and couldn't wait for his pain medication to arrive. He was sent to the emergency department. During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/24/22, Resident #66 requested pain medication and the nurse identified the Oxycodone/acetaminophen 5-325 milligrams had not arrived at the facility yet and did not know why. She called the pharmacy and was told the medication was on the way and would arrive sometime that morning. She indicated when she informed Resident #66 that his pain medication had not arrived yet, the resident requested to be sent to the hospital for pain management as his pain level was 8 out of 10. She stated she sent him to the hospital as he requested for pain management. A nursing note dated 12/24/22 at 10:42 AM revealed Nurse #3 documented Resident #66 returned to facility around 9:15 AM. Resident #66 was alert and oriented with no signs or symptoms of distress and he was ambulatory in his room. The hospital sent 2 Oxycodone/acetaminophen 5-325 milligrams via emergency medical services. During an interview on 1/10/23 at 9:45 AM Physician #1 stated Resident #66 was prescribed Oxycodone/acetaminophen 5-325 milligrams every 4 hours as needed for pain on admission to the facility. He indicated on 12/23/22 he was made aware by a nurse that Resident #66 did not have a hard script, there was no Oxycodone/acetaminophen in the building available for him, and they did not have an emergency kit to pull the medication from. Physician #1 sent the hard script to the pharmacy via fax on 12/23/22 which was a Friday. On the morning of 12/24/22 Physician #1 was notified that Resident #66 had not received his pain medication from the pharmacy and had been in enough pain that he requested to be sent to the hospital due to pain. He indicated the resident received his pain medication at the hospital and returned to the facility the same day. He indicated he saw the resident on 12/26/22 and the resident was fine and did not complain of pain. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/11/23 at 9:40 AM the Director of Client Services for the pharmacy stated the pharmacy received an order for Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as need for pain on 12/23/22 ordered by Physician #1. This order requested 20 pills and two pills had been pulled from the facility emergency backup medicine supply machine so the pharmacy dispensed 18 pills to the facility on [DATE] and this order arrived at the facility on 12/24/22 after the resident went to the hospital. On 12/23/22, after they had received the first order, they also received an order for Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as need for pain, but this order requested 180 pills and was ordered by Physician #1. Because the pharmacy could only fill one of the prescriptions as it was a controlled substance, they filled the 20 pills prescription which had arrived first and did not fill the 180 pills prescription. He stated when a nurse requested to refill any prescription through their electron medical records system at the facility, it would send the request to the pharmacy. Oxycodone/acetaminophen required a hard script for the prescription to be filled so the Pharmacy would request a new order from the facility and then fill the prescription. During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated the resident came to the facility on [DATE]. She verified there was an issue with obtaining a hard script for Oxycodone/acetaminophen which resulted in this medication not arriving from the pharmacy until 12/24/22. She indicated prior to the arrival of the Oxycodone/acetaminophen 5-325 milligrams from the pharmacy, in the early morning of 12/24/22 Resident #66 requested pain medication and was told the medication was on the way. Resident #66 requested to be sent to the hospital for pain management as his pain level was 8 out of 10. He was sent to the hospital and during the time he was at the hospital, a blister pack with 18 Oxycodone/acetaminophen arrived at the facility. When he returned from the hospital his pain was under control. Resident #66's MAR for December 2022 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth in the following dates and times: - 12/24/22 at 11:42 AM, 3:43 PM, and 9:13 PM - 12/25/22 at 4:30 AM, 3:55 PM, and 10:04 PM. - 12/26/22 at 3:03 AM, 8:26 AM, and 6:07 PM - 12/27/22 at 12:46 AM, 5:09 AM, 3:30 PM, and 8:23 PM - 12/28/22 at 1:20 AM, 5:30 AM, 9:31 AM, and 2:23 PM - 12/29/22 at 1:21 AM A nursing note dated 12/29/22 written at 7:43 PM as late entry for 12/29/22 at 10:00 AM revealed Nurse #4 documented Resident #66 was upset that his Oxycodone/acetaminophen 5-milligrams was not available at time requested. Nurse #4 called the Pharmacy to inquire on status of medication delivery. Nurse #4 informed Resident #66 they were waiting on the delivery of medication from the pharmacy. As needed Acetaminophen was offered, however, Resident #66 refused. (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 0755 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/12/23 at 8:56 AM Nurse #4 stated on 12/29/22 she was informed during change of shift when she came to work that Resident #66's pain medication had run out, but the refill was expected that morning. Resident #66 requested pain medication at some point that morning, but she did not know what time it was. It was later in the morning she believed as therapy was coming to work with the resident, and he stated he would not do therapy without his pain medications. She offered him Acetaminophen which he refused. She indicated he was agitated which she stated was understandable as he indicated his pain was at a 10 out of 10. His medication did not arrive that morning, so the nurse requested the Director of Nursing's assistance to contact the physician and pharmacy. A nursing note dated 12/29/22 at 12:05 PM revealed the Director of Nursing documented Resident #66 had complaints of pain. Resident #66 was noted with no more narcotics in the medication cart or available in the facility emergency backup medicine supply machine. The Director of Nursing called the pharmacy and discovered the hospital initially sent a prescription for Oxycodone/acetaminophen 5-325 milligrams for a quantity of 20 tablets. Physician #1 also sent a prescription for 180 tablets. The pharmacy only sent the 20 tablets as they could not fill both prescriptions. The other prescription was available at the pharmacy and was now filled and will be delivered that evening. A phone call was made to Physician #1 with a request for a new order for Oxycodone/acetaminophen 10-325 milligrams as 2 tabs were available in the facility emergency backup medicine supply machine and would be available to dispense until his prescription refill arrives this evening. Normally an order would be refilled by the nurse when it ran out and she did not have a way to show if a refill was requested or not by the nurse. She stated the only answer she got from the pharmacy of why the refill had not arrived was because they had two orders and only filled one. An order dated 12/29/22 revealed Resident #66 was ordered Oxycodone/acetaminophen 10-325 milligrams by mouth every 4 hours for pain. Resident #66's MAR revealed he received Oxycodone/acetaminophen 10-325 milligrams by mouth on 12/29/22 at 12:00 PM and 4:00 PM. A progress note dated 12/30/22 at 12:38 AM revealed Nurse #2 documented Resident #66 had complaints of severe pain and he no longer had any Oxycodone/acetaminophen 5-325 milligram or 10-325 milligram tablets available in the facility. Resident #66 reported 10 out of 10 pain in left arm and shoulder and current pain management was insufficient at that time. Resident #66 requested to go to the hospital for pain management. A nursing note dated 12/30/22 at 3:48 AM revealed Nurse #2 documented Resident #66 arrived back in facility from the hospital with his pain under control. The medical record indicated Resident #66 discharged home on 12/30/22. During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/30/22, Resident #66 requested pain medication and she did not have any Oxycodone/acetaminophen 5-325 milligrams or 10-325 milligrams. She stated she informed the resident she had Acetaminophen and was going to seek other options with the physician as well, and the resident requested to be sent to the hospital for pain management again as his pain level was at a 10 out of 10 and he told her it felt like he was being hit with a hammer. She stated she sent the resident to the hospital and notified the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. Building B. Wing	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hertford Rehabilitation and Healthcare Center	1300 Don Juan Road Hertford, NC 27944

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 0755 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/10/23 at 9:45 AM Physician #1 stated on 12/29/22 he was called by the Director of Nursing, and she informed him that his 18 Oxycodone/acetaminophen pills had run out. She informed him she had two 10-325 milligram Oxycodone/acetaminophen in the facility, and she requested an order to give the resident this dose of the Oxycodone/acetaminophen while waiting for the pharmacy to deliver the medication. He indicated around 3:00 AM on 12/30/22 a nurse called to inform him that Resident #66 was back in the emergency department due to pain because his Oxycodone/acetaminophen still had not arrived at the facility. Physician #1 reported he was working at the hospital that night and called the emergency department to discuss the resident and the emergency department gave the resident pain medication and sent him back to the facility. The resident was scheduled to discharge home that day and he did discharge home as planned. He stated it was not acceptable to let a resident go without his pain medication. During an interview on 1/11/22 at 9:40 AM the Director of Client Services for the pharmacy stated on 12/29/22 the Director of Nursing called the pharmacy to check why the prescription had not been filled. The pharmacy explained that because they had filled the order for the 20 pills, they did not fill the order for 180 pills. The Director of Nursing informed the pharmacy that Resident #66 did not have any Oxycodone/acetaminophen 5-325 milligrams available in the facility and the pharmacy indicated they would fill the 180 pill order at that time. The medication would be on the 9 PM run from the pharmacy which meant it would arrive sometime in the early morning. The order for the 180 pills was dispensed on 12/29/22 and arrived at the facility on the morning of 12/30/22. During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated it was not acceptable for a resident to be in severe pain at the facility due to the lack of ordered pain medication in the facility. She concluded this was why they sent him to the hospital both times as there were no other options and his pain needed to be controlled in that moment.