STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015453	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbiana Health and Rehabilitation, LLC	22969 Highway 25 Columbiana, AL 35051

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, review of the facility's investigative file, review of a facility policy titled, Medication Error ., the facility failed to ensure Resident Identifier (RI) #1, a resident with a history of seizures, received his/her Oxcarbazepine 300 mg (milligrams) QID (four times a day) as ordered. On 05/11/2023 at 10 PM, on 05/12/2023 at 4 AM, 10 AM and 4 PM, RI #1 did not receive the Oxcarbazepine as ordered by the physician; and on 05/13/2023, RI #1 began to have seizures and was sent to ER (Emergency Room) for evaluation. This medication error was significant due to the drug's classification as an anticonvulsant. This deficient practice affected RI #1, one of three residents sampled for the use of anticonvulsant medications. Findings include: Review of a facility policy titled, Medication Error ., dated 04/2020 revealed the following: . Definitions Medication Error/Discrepancy: . an omission of a vital medication due to a . administering error . Significant: Medication errors . 2. Require hospitalization . 4. Require treatment with a prescription medication . Procedures 1. In the event of a significant medication error . immediate action is taken, as necessary, to protect the resident's safety and welfare. RI #1 was admitted to the facility on [DATE] with a diagnosis of Unspecified Convulsions. A review of RI #1's digitally signed Physicians Orders, dated 05/10/2023, revealed RI #1 had a physicians order for (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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Valproic Acid 250/5 ml (milliliters) to be administered 10 ml by way of his/her PEG (Percutaneous Endoscopic Gastrostomy) tube twice a day, Levetiracetam Oral Solution 100 mg/ml to be administered 6 ml by way of his/her PEG tube twice a day and Oxcarbazepine 300 mg to be administered by way of his/her PEG tube four times a day. RI #1's May 2023 eMAR (electronic Medication Administration Record) documentation did not have the required check mark and initials that would indicate the Oxcarbazepine 300 mg had been administered to RI #1 on 05/11/2023 at 10 PM; and on 05/12/2023 at 4 AM, 10 AM and 4 PM. RI #1's Departmental Notes revealed the following: . 5/11/2023 4:43 PM . will be here for 5 days for Respite . 5/13/2023 10:38 AM . At 0755 (7:55 AM), rsident (resident) was observed resting in bed with seizure activity noted. Resident assisted to left side . Resident has a history of seizures. 5/13/2023 10:45 AM . 0820 (8:20) a.m., call placed to (name of Hospice agency) to notify of continued seizure activity . Awaiting further orders. Responsible party notified of current condition . 5/13/2023 10:47 AM . 0840 (8:40 AM), order received from (name of Hospice agency) Medical Director to administer Ativan 2mg x (times) 4 doses every 15 minutes as needed for seizure activity . Resident continues with seizure activity . 5/13/2023 10:49 AM . 0915 (9:15 AM)-family arrives to facility. Resident continues with seizure activity . 5/13/2023 10:50 AM . 0945 (9:45 AM) Resident continues with seizure activity. Ativan x 4 doses has been administered. (Name of Hospice agency) updated on resident's status. Family wishes for resident to be sent to (name of hospital) for further evaluation . 5/13/2023 10:53 AM . 1012 (10:12) am (a.m.) resident picked up by EMS (Emergency Medical Services) for transport to (name of hospital) and further evaluation . 5/13/2023 3:37 PM . UPON TRANSPORT TO ACUTE CARE, RESIDENT CONTINUED WITH SEIZURE ACTIVITY . E.R. REPORTS RESIDENT WILL BE admitted TO HOSPITAL FOR UNCONTROLLED SEIZURES . A review of RI #1's ED (Emergency Department) Notes, dated 05/13/2023, revealed the following: . HISTORY OF PRESENT ILLNESS . Patient transported by EMS from the nursing home for evaluation after experiencing seizures this morning. (He/She) does have a history of seizures . The paramedic was concerned that (he/she) had had continued seizures and that (he/she) had received Ativan and Versed . ED Clinical Impression (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Seizures . Assessment & (and) Plan: Seizure disorder . Chief Complaint Patient presents with • Seizures HPI (History of Present Illness): Patient . with a history of . Seizures . who presented to the ED via (by way of) EMS d/t (due to) seizures at (his/her) nursing home. Per EMS there were concerns for continued seizures en route to hospital, and (he/she) received ativan and versed . Discussed in detail with (family member) . (family member) also states that she was concerned the nursing home was not giving . seizure meds (medications) . Past Medical History: Diagnosis . • Unspecified convulsions . On 05/15/2023, the State Agency received a FRI that stated RI #1's anti-seizure medications were not administered; and substantiated RI #1's Oxcarbazepine 300 mg to be given four times a day was not given as ordered. Review of the facility's investigative file revealed a form titled VERIFICATION OF INVESTIGATION, dated 05/15/2023, which documented the following: . PROVIDE SUMMARY AND OUTCOME OF INVESTIGATION: . Review would indicate that Oxcarbazepine 300 MG was entered into facility system on 5/11/2023 at 4:45 PM. When the order was activated the start date was entered as 5/18/2023 at 10:00 PM. The clerical error was identified on 5/12/2023 . at 7:24 PM . the clerical error resulted in missed does of Oxcarbazepine . Facility is able to verify allegation that medications were missed. Missed medications were a result of a simple clerical error . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 05/18/2024 at 8:45 AM, a telephone interview was conducted with RI #1's responsible party who said RI #1 was admitted to the facility on [DATE] (a Thursday) for respite care. RI #1's responsible said she found out RI #1 was not receiving his/her seizure medications as ordered by the physician when she went to the nursing home to pick up RI #1's belongings. The responsible party said when she was given RI #1's bubble packs of medications, she noticed not enough pills were missing from the pack. RI #1's responsible party said one of the nurses called her two days after RI #1 had been in the facility and informed her RI #1 was seizing. RI #1's responsible party said when she got to the facility, RI #1 was shaking and his/her eyes were rolling in the back of his/her head. RI #1's responsible party said they kept giving RI #1 some kind of medication to help stop the seizures but RI #1 continued to seize, and she finally asked them to send RI #1 out. On 04/18/2024 at 11:49 AM, an interview was conducted with Registered Nurse (RN) #3, the nurse providing care for RI #1 on 05/13/2023. RN #3 said RI #1 was admitted on the anticonvulsant medication Oxcarbazepine. RN #3 said RI #1 did not receive the Oxcarbazepine at 10 PM on the 11th (05/11/2023), and at 4 AM, 10 AM and 4 PM on the 12th (05/12/2023). RN #1 said it looked like the order was put in incorrectly. RN #3 said on 05/13/2023, RI #1 was observed with seizure activity, RI #1's Hospice agency staff (HAS) and RI #1's responsible party were notified, and RI #1 was sent to the hospital for further evaluation. RN #3 said finding from the facility's investigation revealed RI #1 did not receive a couple of doses of his/her anticonvulsant medications. When asked what harm could occur when a resident is not administered their anticonvulsant medications, RN #3 said they could experience seizure activity. On 04/18/2023 at 2:14 PM, a telephone interview was conducted with a member of RI #1's HAS. The HAS member said a facility nurse called one of the on-call HAS members over the weekend and informed them RI #1 had a seizure. The HAS said the harm in RI #1 not receiving his/her anticonvulsant medications as prescribed by the physician would probably be RI #1 was going to have a seizure. On 04/18/2024 at 3:30 PM, a telephone interview was conducted with the Medical Director (MD). The MD said from his understanding when RI #1 was admitted to the facility the person who entered the orders clicked on the calendar on the date for the 11th and the cursor may have dropped to the line below, so the order went in for the start of the seizure medication to start on the 18th instead of the 11th. The MD said the harm in not receiving your seizure medications is the risk of having a seizure and that sounds like that was what happened. The MD said there was an error in putting the order in. The MD said the date was put in incorrectly. On 04/18/2024 at 4:03 PM, the surveyor conducted an interview with the Director of Nursing (DON). The DON said RI #1 was admitted to the facility on [DATE] for Respite care. The DON said RI #1 was admitted on Oxcarbazepine 300 mg to be given QID and the anticonvulsant medications was not transcribed to RI #1's MAR correctly. The DON said the Oxcarbazepine was missed at 10 PM on 05/11/2023 and missed on 05/12/2023 at 4 AM, 10 AM, and 4 PM. The DON said RI #1 did experience a seizure while a resident at the facility and was sent out. The DON said finding from the facility's investigation revealed a clerical error occurred. When asked what harm could occur when a resident is not administered their anticonvulsant medications as ordered, the DON said the resident could have seizures. On 04/18/2024 at 5:02 PM, a telephone interview was conducted with the Consultant Pharmacist (CP). When asked what type error it would be when medications are not administered as ordered by the physician, the CP said a medication error. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	This deficiency was cited as result of the investigation of complaint/report #AL00044229. ********** The facility took immediate action: 5/11/23 4:43 PM Resident admitted to facility. Assessment completed per RN. Medication orders entered into electronic medical record. 5/12/23 - New orders reviewed. Noted start date for Oxcarbazepine entered as 5/18/23 in error. Medication order corrected with start date of 5/12/23. 5/13/23 7:55 AM - Resident noted with seizure activity. Assisted to left side. TF (Tube Feeding) placed on hold. Oral secretions noted, suction provided. 5/13/23 8:20 AM - Seizure activity continues. Sponsor notified. Expect Care Hospice notified. 5/13/23 8:40 AM - Expect Care Hospice MD gave orders to administer Ativan 2mg every 15 minutes x 4 doses. 5/13/23 9:15 AM - Seizure activity continues. Resident vomiting. Family arrived at facility. Expect Care Hospice enroute to facility. 5/13/23 9:45 AM - Seizure activity continues. Bleeding noted from mouth. Ativan administered. Hospice notified of current status, still enroute to facility. Sponsor requested resident be sent to ER. 5/13/23 10:12 AM - Resident left facility via EMS to hospital. 5/15/23 - Expect Care Social Worker called facility admissions coordinator to report that family did not wish for resident to return to facility. DON and SW called family to discuss concerns. After discussion, an allegation was reported to ADPH. 5/15/23 - An investigation was initiated regarding the allegations made by family. 5/16/23 - An emergency QAPI meeting was held to discuss the allegation and the ongoing investigation. 5/16/23 - Education was initiated to nursing management regarding medication order input, peer review and submission to pharmacy and clinical meeting guidelines. 5/16/23 - All new medication orders that were obtained between 5/11/23 - 5/15/23 were reviewed to ensure that all were entered into the electronic record correctly. (No other issues were identified.) 5/16/23 - Nurses notes entered between 5/11/23 - 5/15/23 were reviewed for identification of any noted change in the resident' condition with noted seizure activity or medication not available. (No other issues were identified.) ********** (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	After review and verification of the information provided in the facility's corrective action plan, in-service education records, monitoring tools, and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 05/12/2023 through 05/16/2023 with ongoing monitoring implemented; thus, past noncompliance was cited.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, resident record review, and review of a facility policy titled, Hand Hygiene, the facility failed to ensure Certified Nursing Assistant (CNA) #9, performed hand hygiene and used Personal Protective Equipment (PPE) in a manner to prevent cross-contamination. On 04/17/2024 CNA #9 failed to perform hand hygiene after removing contaminated gloves, and before handling clean linens while providing incontinent care for Resident Identifier (RI) #5. This deficient practice affected RI #5; one of one resident observed receiving incontinent care. Findings include: Review of a facility policy titled, Hand Hygiene, with an effective date of 06/11/2020, revealed the following: PURPOSE: To provide guidelines to employees for proper and appropriate hand washing techniques that will aide in the prevention of the transmission of infections. STANDARD: Handwashing should be performed between procedures with residents . based upon the principle that . body fluids, secretions, excretions . may contain transmissible infectious agents. PROCESS: . III. Hand Hygiene Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. • Before and after assisting a resident/guest with toileting . • After handling soiled or used linens Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. RI #5 was originally admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/2024 at 2:38 PM, CNA #8 and CNA #9 were observing providing incontinent care for RI #5. CNA #9 while wearing gloves, wiped bowel movement from RI #5's right buttocks, disposed of the incontinence wipe, and disposed of RI #5's wet brief. CNA #9 then straightened the clean linen and secured RI #5's clean brief while wearing the soiled gloves. On 04/17/2024 at 5:45 PM, CNA #9 was asked about hand hygiene and glove use. CNA #9 said, staff were supposed to change gloves and put on a new pair of gloves before touching clean items such as linen. CNA #9 was asked what was the risk of handling clean materials (such as linen) while wearing contaminated gloves. CNA #9 replied, spreading germ and body fluids. CNA #9 was asked when she performed incontinent care on RI #5, did she perform care the correct way. CNA #9 replied no, she did not change her gloves as often as she should have. On 04/18/2024 at 9:15 AM, the Infection Control Preventionist (IP) was interviewed. The IP was asked, according to the facility's policy, when was staff supposed to wash their hands. The IP replied, anytime hands were visibly soiled and before and after patient care. The IP was asked when should staff remove soiled gloves. The IP replied, between residents, before entering a hallway, and during and after perineal care. The IP was asked if staff should wear contaminated gloves when handling clean linen. The IP replied, no. The IP was asked what was the risk of picking up clean linen with dirty/soiled gloves on. The IP replied, spread of infection. On 04/18/2024 at 9:30 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC was asked, according to the facility's policy, when was staff supposed to wash their hands. The SDC replied, before entering a resident room, after glove removal, and staff should sanitize their hands after leaving a resident's room. The SDC was asked what could be the risk of not washing your hands before entering a resident's room. The SDC replied, the spread of infection. The SDC was asked when should staff remove soiled gloves. The SDC replied, before touching clean linens, after perineal care and anytime staff touches a clean surface. The SDC was asked should staff be wearing contaminated gloves when handling clean linen. The SDC replied no. The SDC was asked what was the risk of picking up clean linen with dirty/soiled gloves on. The SDC replied, the linen becomes contaminated, and you could spread infection when placing it on the resident.