STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015464	A. Building B. Wing	06/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Physical Recovery Center at Hoover, LLC	575 Southland Drive Hoover, AL 35226

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 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. Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to provide dependent residents assistance with activities of daily living (ADLs) to ensure good grooming for one (Residents #449) of seven residents reviewed for ADL care. Specifically, the facility failed to shave Resident #449 when needed. Findings included: The facility's policy, titled, Hygiene and Grooming, dated 10/01/2010, indicated, Good hygiene and grooming help prevent the spread of infection and promote the resident's feeling of self-worth and dignity. Guidelines for the provision of hygiene and grooming services are: -Shower, tub or complete bed bath as needed -Twice daily oral hygiene (A.M. and P.M.) -Hair and scalp shampoo, as needed -Shaving daily or as needed. A review of a FACE SHEET indicated the facility admitted Resident #449 on 05/12/2023 with diagnoses that included Fusion of the Cervicothoracic Spine (bones in the neck and upper back), Osteomyelitis (infection of the bone) of the Lumbar Vertebra (bones in the lower back), Kyphosis (curvature of the spine), and Chronic Pain. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/19/2023, revealed Resident #449 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The resident required extensive assistance from staff with bed mobility, transfers, dressing, and toilet use and required supervision with set-up help from staff only for personal hygiene. Review of Resident #449's Care Plan, initiated 05/15/2023, revealed the resident required assistance to complete daily activities of care safely. Interventions directed staff to assist with shaving. On 05/30/2023 at 11:27 AM, Resident #449 was observed sitting up in their wheelchair with their lunch tray on the over-the-bed table in front of the resident. The resident had a couple of days' hair growth on their face. The resident was wearing a hospital gown with a gait belt around them. On 06/01/2023 at 10:39 AM, Resident #449 was observed lying on the bed and continued to have (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: 015464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2023
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	several days of hair growth on their face. The resident was interviewed during this time and stated they preferred to be clean shaved and really needed to be shaved. Resident #449 stated they could do it themself if staff would give them the supplies to do it. On 06/03/2023 at 9:37 AM, Resident #449 was observed lying on the bed and had not been shaved. During an interview at this time, the resident again stated if the staff would give them the supplies, the resident would do it themself. Resident #449 stated they had asked the staff for supplies, but they did not help. A review of Resident #449's May 2023 ADL Assistance and Support form revealed the personal hygiene section was incomplete. It had not been filled in for the entire month. There was no documentation of the resident receiving assistance with personal hygiene. During an interview on 06/03/2023 at 9:55 AM, Unit Manager (UM) #8 stated residents should be shaved when they preferred to be shaved or be assisted or set up to do it themselves. During an interview on 06/03/2023 at 10:23 AM, Certified Nursing Assistant (CNA) #9 stated she shaved residents when they requested to be shaved. She did not think Resident #449 would be able to shave themself and stated she was not aware the resident wanted to be shaved. During an interview on 06/03/2023 at 5:15 PM, the Director of Nursing (DON) stated residents should be shaved every time they got a shower, if not every day. During an interview on 06/03/2023 at 5:56 PM, the Executive Director (ED) stated residents should be shaved as needed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility document and policy review, it was determined the facility failed to provide care and treatment in accordance with professional standards of practice to meet the needs of five (Residents #98, #141, #454, #112, and #300) of 50 sampled residents. Specifically, the facility failed to: 1. Obtain orders for the care and monitoring of a peripherally inserted central catheter (PICC) line for Resident #98; 2. Transcribe orders for care of a surgical wound for Resident #141; 3. Ensure care of a surgical wound was completed as ordered for Resident #112; and 4. Ensure coordination between the facility and Resident #300's hospice provider regarding who would provide the resident's medications while in the facility for respite care (generally a short-term temporary admission, usually for residents receiving hospice benefits). As a result, Resident #300 did not receive their medications as ordered by a physician. Findings included: 1. A review of a FACE SHEET indicated the facility admitted Resident #98 on 05/03/2023 with diagnoses that included Orthopedic Aftercare Following the Surgical Amputation of the Right Leg Above the Knee. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/10/2023, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident required supervision from staff with all activities of daily living (ADLs). Review of Resident #98's care plan, initiated 05/04/2023, indicated a potential for complications related to a central line (right double lumen PICC line). Interventions instructed staff to clean the central line site as ordered, observe for signs of infection, flush the central line as ordered, and notify the physician if staff were unable to flush the port. During an interview on 05/30/2023 at 12:29 PM, Resident #98 confirmed they had a PICC line and wanted it removed before they were discharged that day. A review of a Departmental Note, dated 05/03/2023, indicated Resident #98 arrived at the facility via ambulance and had a right double lumen PICC line. The note indicated the dressing was last changed on 04/29/2023. Further review of the Departmental Notes revealed no further documentation of the PICC line. A review of Resident #98's May 2023 Physician Orders revealed no orders to monitor or flush the PICC line nor to change the dressing. A review of Resident #98's May 2023 MAR [Medication Administration Record] revealed no directions for staff to monitor the PICC line and no documentation of the PICC line being flushed or the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing being changed. During an interview on 06/03/2023 at 9:55 AM, Unit Manager #8 stated Resident #98 did have a PICC line, but it was not being used for anything while at the facility. She stated she had completed dressing changes and flushed the PICC line. During an interview on 06/03/2023 at 10:25 AM, the Director of Nursing (DON) stated the PICC line was not used for the resident while they were at the facility, but the DON was having trouble locating documentation regarding the PICC line. During an interview on 06/03/2023 at 5:56 PM, the Executive Director stated he expected the staff to provide whatever care was necessary for a PICC line. 2. A review of Resident #141's FACE SHEET revealed the facility admitted the resident on 03/15/2023 with diagnoses that Included Aftercare Following Joint Replacement Surgery, Presence of a Right Artificial Knee Joint, Obesity, Anxiety Disorder, Hypertension, Gastro-esophageal Reflux Disease (GERD), and Hypokalemia (low potassium). Resident #141 was discharged on 03/24/2023. A review of a five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/22/2023, revealed Resident #141 was independent with daily decision making according to a Staff Assessment for Mental Status (SAMS). Per the MDS, the resident was independent with eating and personal hygiene; required supervision from staff with set-up help only for transfers, walking in the room or corridor, and toilet use; limited assistance of one person for bed mobility, locomotion on and off the unit; extensive assistance from staff for dressing, and physical help for part of the bathing activity. The MDS indicated the resident had a surgical wound. A review of Resident #141's Care Plan, dated 03/16/2023, indicated the resident had a surgical incision/wound related to a right total knee arthroplasty (TKA). The Care Plan instructed the staff to assess wound healing weekly, do full skin evaluations with a bath or shower, assess the skin daily with routine care, assess and treat pain if present, reduce incisional pressure with position changes, encourage good nutritional intake, and assess changes in skin status that indicated worsening of the surgical wound and notify the physician. A review of a Patient Transfer Form from the discharging hospital, dated 03/15/2023, indicated Resident #141 had a right total knee arthroplasty (TKA or knee replacement) on 03/13/2023 with recommendations to change the silver dressing to the right knee every seven days. A review of an admission Checklist, dated 03/15/2023, indicated wound care was a need for Resident #141. A review Resident #141's Nursing admission Review, dated 03/15/2023, revealed it was incomplete. The Skin Integrity section of the assessment was not completed. A review of Resident #141's Physician Orders for the month of March 2023 revealed no wound care or treatment orders for the surgical wound to the resident's right knee. A review of Resident #141's MAR [Medication Administration Record] revealed no directions or orders for the treatment of the surgical wound to the resident's right knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Departmental Notes for the timeframe from 03/15/2023 through 03/23/2023 revealed no documentation regarding the resident's skin integrity, appearance of the incision to the right knee, or treatment to the surgical wound being provided. During an interview on 06/03/2023 at 9:55 AM, Unit Manager #8 stated medical records staff entered admission orders into the computer. She stated once a resident arrived, a nurse reviewed paperwork sent with the resident from the hospital and compared it with what was in the computer. She stated usually when a resident came with a dressing to a surgical wound, there were orders to leave the dressing in place for at least seven days. She stated if the resident had a surgical wound and had no physician orders to treat the wound, she would notify the wound nurse and the wound nurse would assess the resident and obtain orders. During an interview on 06/03/2023 at 5:15 PM, the Director of Nursing (DON) stated the admissions staff person received orders from the hospital and then sent them out to the different departments. She stated the medical records staff was also a nurse and entered orders in the computer. She stated the next day, staff reviewed all hospital orders to ensure they captured everything. The DON stated an admission body audit should be completed and the wound nurse should be notified of skin issues so the wound nurse could also assess and obtain physician orders. The DON noted she did not work at the facility during the time Resident #141 was at the facility and could not comment on why treatment orders were not entered for the surgical wound to the resident's right knee. During an interview on 06/03/2023 at 5:56 PM, the Executive Director stated when a resident was admitted to the facility, medical records staff entered the orders the facility received from the referral source. He stated he did not know whether the orders were verified by the physician or by another nurse. He stated he expected orders to be transcribed correctly, timely, and followed. 3. A review of the facility's policy titled Dressings-Clean dated 12/20/2016 revealed the purpose of the policy was To provide guidelines for the care of wounds and soiled dressings, to decrease the potential for nosocomial infection. Each wound site should be treated individually. The policy indicated the standard was Physician's orders should specify type of wound, frequency of change, type of dressing or products to be used. A review of a FACE SHEET revealed the facility readmitted Resident #112 on 03/10/2023 with diagnoses that included Major Laceration of the Spleen, Major Laceration of the Liver, Hemoperitoneum, and Contusion of of the Colon. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/17/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident had a surgical wound. Review of Resident #112's care plan, dated 03/15/2023, indicated the resident had a surgical incision/wound with a goal for the resident to be free of complications related to their surgical wound. Interventions directed staff to assess changes in skin status that indicated worsening of the surgical wound and reassess the treatment plan if the wound was not healing within two to four weeks. Review of Resident #112's Departmental Notes, dated 05/15/2023 and written by a licensed practical nurse, revealed the resident visited a burn center and orthopedic doctor and new orders were received to change the dressing to the abdominal wound twice daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #112's wound care orders, dated 05/15/2023, indicated the abdominal surgical wound dressing was to be changed twice daily. The order directed staff to cleanse the resident's abdominal wound bed with Vashe wound cleanser, apply Xeroform gauze to the wound bed, cover with sterile gauze, apply abdominal (ABD) pads to cover the area, and secure with Ominifix retention tape. Prior to 05/15/2023, the treatment was to be completed daily. Review of Resident #112's May 2023 TAR [Treatment Administration Record] revealed the abdominal wound dressing was to be changed daily at 8:00 AM and 8:00 PM. The TAR documentation did not indicate the wound treatment was provided at 8:00 AM on 05/28/2023, 05/30/2023 and 05/31/2023 or at 8:00 PM on 05/19/2023, 05/20/2023, 05/21/2023, 05/22/2023, 05/23/2023, 05/25/2023, 05/26/2023, 05/27/2023, 05/29/2023, 05/30/2023, and 05/31/2023. During an interview with Resident #112 on 05/30/2023 at 10:45 AM, the resident stated that their evening wound care was not always being provided. During an interview on 06/02/2023 at 5:03 PM with Registered Nurse (RN) #20, the Treatment Nurse, she stated RN #22 and Resident #112 had complained to her that evening wound care was not being provided by other nurses as ordered. During an interview with RN #22 on 06/02/2023 at 5:32 PM, she stated some staff would conduct wound care and some would not. During an interview with Unit Manager #8 on 06/03/2023 at 10:08 AM, she stated the nurses assigned to provide the resident's care were supposed to complete the wound treatment if the wound treatment nurses were not working. She noted that wound treatment nurses worked during the day shift Monday through Friday. During an interview with the Nurse Consultant on 06/03/2023 at 4:36 PM, she stated she knew Resident #112's wounds treatments were not being performed. She said risks associated with wound care not being completed included infection. She stated she expected the staff to provide the wound care as ordered. During an interview with the Director of Nursing on 06/03/2023 at 5:14 PM, she stated she expected staff to follow physician's orders and provide wound care as ordered. She stated she was not aware Resident #112's wound care was not being completed until that week. She stated not conducting wound care as ordered put the resident at risk for infection. During an interview with the Executive Director (ED) on 06/03/2023 at 5:10 PM, he indicated that there was no policy related to following physician orders and stated it was a standard of practice. During a follow up interview with the ED on 06/03/2023 at 5:54 PM, he stated he expected staff to provide wound care as ordered. He stated he was not aware the wound care was not being conducted for Resident #112. He stated the risks associated with wound care not being conducted included worsening of the wound. 4. A review of Resident #300's FACE SHEET revealed the facility admitted the resident on 04/15/2022 with diagnoses that included cerebrovascular disease, vascular dementia, insomnia, and hypertensive heart failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #300's Care Plan, initiated on 04/16/2022, indicated the resident was at risk for complications related to Hypertension, Diabetes, Anti-anxiety Medication Use, Anti-depressant Medication Use, and Anti-Psychotic Medication Use. The Care Plan directed staff to administer medications as ordered for diabetes, administer antianxiety medication as ordered, and administer behavior medications as ordered. A review of Resident #300's Physician Orders List revealed orders dated 04/15/2022 for the following: - Admit to Aspire [NAME] for respite care; - Trazodone 100 milligram (mg) tablet, take one tablet by mouth at bedtime for Depression - Klonopin 0.5 mg tablet, take one tablet by mouth at bedtime for Anxiety - Lorazepam 1 mg tablet, take one tablet by mouth at bedtime for Anxiety - Novolog Flexpen U-100 insulin aspart 100 units per milliliter (units/mL), give per sliding scale order three times daily before meals and at bedtime for Diabetes - Loperamide 2 mg tablet, give two tablets to equal 4 mg by mouth and one tablet by mouth after each loose stool a needed for Diarrhea - Promethazine 25 mg rectal suppository, give one suppository rectally every four to six hours as needed for nausea and vomiting - Senna-S 8.6 mg-50 mg tablet, take one tablet by mouth twice per day for constipation -Aspirin 81 mg delayed release, take one tablet by mouth daily for heart health - Donepezil 10 mg tablet, take one tablet by mouth daily for Dementia - Lactulose 10 grams per 15 milliliter (mL) oral solution, 15 mL by mouth daily for constipation - Tresiba FlexTouch U-100 insulin subcutaneous pen, inject 14 units subcutaneously daily for Diabetes - Hydrochlorothiazide 12.5 mg tablet, one tablet by mouth daily for edema - Losartan 25 mg tablet, take one tablet by mouth daily for Hypertension - Docusate Sodium 100 mg tablet, one tablet by mouth at bedtime for constipation - Diclofenac 1 percent (%) topical gel, apply 2 grams topically four times a day to affected areas as needed for pain - Hydrocodone 5 mg- acetaminophen 325 mg tablets, take one tablet every eight hours for pain - Tramadol 100 mg tablet, take one tablet every eight hours for pain (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Meloxicam 7.5 mg tablet, take one tablet by mouth daily for pain - Risperidone 1 mg disintegrating tablet, take one tablet twice a day for behaviors Each medication order included a note to the pharmacy that indicated, do not send [,] FAMILY TO PROVIDE**. A review of Resident #300's April 2022 MAR [Medication Administration Record] revealed ordered medications were not administered on the following dates: - Trazodone was not administered on 04/15/2022, 04/18/2022, or 04/19/2022 - Lorazepam was not administered from 04/15/2022 to 04/19/2022 - Donepezil, Hydrochlorothiazide, Losartan, Loperamide, Promethazine, Meloxicam, Diclofenac, and Risperidone were not administered from 04/16/2022 to 04/20/2022 - Lactulose oral solution was not administered from 04/18/2022 to 04/20/2022 - Tresiba FlexTouch U-100 insulin was not administered on 04/16/2022 or 04/18/2022-04/20/2022, - Docusate Sodium was not administered on 04/18/2022 or 04/19/2022, - Senna-S 8.6mg-50 mg tablet was not administered on 04/18/2022-04/20/2022, and - Hydrocodone-Acetaminophen and tramadol were not administered on 04/16/2022 or 04/18/2022-04/20/2022. A review of a Confirmation of Receipt of Online Incident Report from the Alabama Department of Public Health Online Incident Reporting System, dated 04/21/2022, revealed the facility reported to the state agency that Resident #300's family alleged medications were not given as ordered during the resident's respite stay. A review of a Verification of Investigation, signed by the facility Executive Director (ED) on 04/27/2022, revealed Resident #300 was admitted to the facility for a five-day respite stay on 04/15/2022. The facility determined there was a misunderstanding between hospice and the facility as to who would provide the resident's medications. According to the Verification of Investigation, the family provided only the resident's Klonopin, Hydrocodone-Acetaminophen, and Insulin and, while nursing staff pulled some of the resident's ordered medications from house stock, the remaining medications were not received, as it was the facility's understanding they were not to order them from the pharmacy because the family would be providing the medications. A review of a Quality Assurance Committee Action form, dated 04/21/2022, indicated one-on-one education was completed with the nurses involved, an audit was conducted of all respite residents in the facility at the time of 04/21/2022, in-service education was provided for all licensed nursing staff regarding medication administration, sponsors were called for respite residents to attempt to obtain medications, the pharmacy and physician were contacted if a medication was not available to be given, and eight weeks of monitoring was initiated to ensure all medications were given as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/20/2023 at 10:57 AM, the ED of Resident #300's hospice company indicated if there was a situation where the family could not bring in medications or they did not have enough, hospice would call in the orders. The hospice Executive Director also indicated there was an occurrence with Resident #300 where hospice was not notified until day four of the resident's stay that the resident did not have all their medications. The investigation revealed there was miscommunication from the facility because the hospice policy was that family would always bring in medications for respite care. The family brought in the some of the resident's medications, but Resident #300 did not get any of the other routine medications while at the facility. During an interview on 06/23/2023 at 9:17 AM, LPN #3 indicated she remembered talking to the previous leadership team about the situation with Resident #300. She remembered that it was a big issue and said since then, a hospice nurse was required to come in with the respite resident, and the hospice nurse or the family would bring in the medications. During an interview on 06/25/2023 at 12:04 PM, the DON indicated that for respite care, the admissions office received the medications and got with the hospice nurse. Some families brought in the medications. The DON indicated her expectation was that hospice would provide a list of medications and if the family did not bring in the medications, the facility nurse needed to find out what was going on. If the family did not bring the medications in, the DON expected the pharmacy to fill the orders so the resident could have their medications. During an interview on 06/25/2023 at 12:28 PM, the facility ED indicated his expectation was for the facility to have the medications for residents on respite care and they be administered as ordered and indicated if for some reason the family did not provide the medications, they would be ordered from the pharmacy. This deficiency was cited as a result of complaint/report #AL00041888, #AL00042116, and #AL00043725

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews, record review, and facility policy review, it was determined that the facility failed to ensure medications were available from the pharmacy for two (Resident #452 and Resident #142) of six residents reviewed for unnecessary medications. Specifically, the facility failed to ensure Resident #452's Prednisone and Resident #142's inhaler was available from the pharmacy for administration. Findings included: Review of a facility policy titled, Medication Policies Ordering and Receiving Medications from Provider Pharmacy, dated 04/2020, specified, .Medications and related products are received from the provider pharmacy on a timely basis. Procedures 1. A. New medication orders are transmitted to the pharmacy. C. The first dose of non-emergency medication is scheduled to be given after the regularly scheduled pharmacy delivery to the facility . 1. A review of a FACE SHEET indicated the facility admitted Resident #452 on 05/26/2023 with diagnoses that included Asthma and Acute Respiratory Failure with Hypoxia (below normal level of oxygen in the blood). The resident was not at the facility long enough for a Minimum Data Set (MDS) to be completed. Review of Resident #452's Care Plan, initiated 05/29/2023, revealed the resident had altered respiratory function related to shortness of breath and asthma. Interventions directed staff to observe for effectiveness of medication, observe for changes in respiratory rate and depth, and observe for shortness of breath, congestion, or cyanosis (bluish skin color due to decreased amounts of oxygen). A review of Resident #452's May 2023 Physician Orders revealed the resident had an order to administer one tablet of Prednisone 10 milligram (mg) orally once daily for six days, ordered 05/26/2023. A review of Resident #452's May 2023 Med [medication] Tech [technician] (Administration Record) revealed the resident did not receive their Prednisone for the first three days after they were admitted to the facility, on 05/27/2023, 05/28/2023, or 05/29/2023. A review of a Consolidated Delivery Sheets from the pharmacy, dated 05/30/2023, indicated 21 tablets of Resident #452's Prednisone 10 mg were delivered. During an interview on 06/02/2023 at 11:28 AM, Medication Aide Certified (MAC) #23 stated if a medication was not available during the medication pass, she would notify the nurse and they would do the follow-up. She stated she could not remember what nurse she talked to about Resident #452's prednisone. During an interview on 06/02/2023 at 3:30 PM, Licensed Practical Nurse (LPN) #11 stated if a medication was not available during the medication pass, they should notify the pharmacy and the physician and document it. She stated medications should be available for administration by the next medication pass. LPN #11 was not working on the floor yet when the omission of Resident #452's prednisone occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2023
NAME OF PROVIDER OR SUPPLIER Aspire Physical Recovery Center at Hoover, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 575 Southland Drive Hoover, AL 35226	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/03/2023 at 9:55 AM, Unit Manager (UM) #8 stated if a medication was not available during the medication pass, staff should check to see if it was available in the emergency medication kit and then call the pharmacy to find out when it was going to be delivered. She stated the pharmacy delivered between 11:00 AM to 12:00 PM, then between 6:00 PM and 7:00 PM, and then again overnight. She stated if a medication was not available on the first pharmacy run then it should be on the next one. If it was not, then she would call the pharmacy. She stated most of the time the MAC would tell her when they did not have a medication to administer. She stated she was not aware that Resident #452 did not receive their prednisone. During an interview on 06/03/2023 at 5:15 PM, the Director of Nursing (DON) stated if a MAC did not have a medication available to administer, then they should notify the nurse, and the nurse should contact the pharmacy to find out where the medication was and contact the physician to notify that the medication was not available. During an interview on 06/03/2023 at 5:56 PM, the Executive Director (ED) stated if a medication was not available during the medication pass, then they needed to find out where the medication was and notify the physician that the medication was not available. 2. A review of Resident #142's FACE SHEET revealed the facility admitted the resident on 02/27/2023 with diagnoses that included Pneumonia, Dementia, Heart Failure, Acute Respiratory Failure, and Chronic Obstructive Pulmonary Disease. A review of Resident #142's five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2023, revealed the resident did not experience shortness of breath or trouble breathing during this assessment period. A review of Resident #142's care plan initiated on 02/28/2023, indicated the resident had altered respiratory function related to respiratory failure. The interventions included to observe for the effectiveness of medication, observe for changes in respiratory f rate and depth, observe for shortness of breath, congestion, cyanosis (a bluish discoloration of the skin that can result from poor circulation or inadequate oxygenation of the blood), and pharmacy consult as needed. A review of Resident #142's Physician Orders, dated March 2023, revealed on 02/27/2023, the resident received an order for Anoro Ellipta with instructions to inhale into the lungs daily for shortness of breath and wheezing. A review of Resident #142's Med [medication] Tech [technician] (Administration Record), for March 2023, revealed staff did not administer the Anora Ellipta inhaler on 03/07/2023 and 03/08/2023. The Administration Record note dated 03/07/2023 indicated the medication was not administered as the medication was not available. The note dated 03/08/2023 written by Medication Aide, Certified (MAC) #23, indicated the medication was not administered as the medication was not available and was ordered from pharmacy. During an interview on 06/03/2023 at 10:02 AM, Unit Manager (UM) #8 stated if there was a missing medication, staff should go to Hall 2 to check the backup medications, and if not there, call the pharmacy. UM #8 stated the pharmacy delivered medications three times per day. During an interview on 06/03/2023 at 11:05 AM, the Nurse Consultant (NC) stated the expectation was for the staff to look around for the medications on the other medication carts, notify the nurse, (continued on next page)

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	015464	A. Building B. Wing	06/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Physical Recovery Center at Hoover, LLC	575 Southland Drive Hoover, AL 35226

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and notify the pharmacy. The NC stated it was not acceptable for a resident to miss any doses of their medication. Per the NC, a medication aide should notify the nurse that a resident missed a dose of their medication, so the nurse could notify the physician and/or nurse practitioner. During an interview on 06/03/2023 at 11:35 AM, MAC #23 stated she wrote not given on the administration record on 03/08/2023 because she did not know exactly what to do. Per MAC #23, was reeducated since then to inform the nurse and the physician because it may have been a medication the resident should not have missed. During an interview on 06/03/2023 at 5:59 PM, the Executive Director stated his expectation was for staff to follow the physician's orders. This deficiency was cited as a result of complaint/report #AL00043835.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, and facility policies titled Medication Administration-General Guidelines and Blood Glucose Testing the facility failed to ensure adequate monitoring of blood glucose (sugar) levels as ordered by the physician for the use of insulin for Resident #143 and #294, two of five residents reviewed for unnecessary medications. Findings included: Review of a facility policy titled, Medication Administration-General Guidelines, dated 2011, specified, . Medications are administered in accordance with written order of the attending physician . A review of a facility policy titled, Blood Glucose Testing, revised on 10/01/2019, revealed, .The physician's order should specify the type of specimen to be obtained. Blood glucose levels for residents with diabetes vary, depending on food intake, medication, and exercise . A review of Resident #143's FACE SHEET revealed the facility admitted the resident on 03/16/2023 with diagnoses that included Type Two Diabetes. A review of a discharge Minimum Data Set (MDS), dated [DATE], revealed Resident #143 lacked a Brief Interview for Mental Status (BIMS) score, indicating the resident had severe cognitive impairment. Per the MDS, the resident required supervision to limited assistance with all activities of daily living (ADLs). Review of Resident #143's Physician Orders for the month of 03/2023 revealed an order dated 03/16/2023 directing staff to conduct capillary blood glucose (CBG) monitoring every morning, to administer three units of Insulin Aspart three times a day with meals, and to administer nine units of Semglee (Insulin Glargine) at bedtime. Review of Resident #143's Medication Administration Record (MAR), dated March 2023, revealed staff failed to obtain ordered CBG checks on 03/19/2023. Review of a nursing Progress Note, dated 03/20/2023 at 10:57 PM, indicated Licensed Practical Nurse (LPN) #16 entered Resident #143's room to check the resident's blood glucose level and found Resident #143 standing and wobbling. When LPN #16 assisted Resident #143 to a chair, the resident began shaking and was unable to keep their eyes open. LPN #16 checked the resident's blood glucose level, which was severely elevated at 537 milligrams/deciliter (mg/dL). When checked again, the blood glucose measured 517 mg/dL. Resident #143's vital signs were noted to be unstable. Hospice services was contacted and gave orders to send the resident to an emergency department (ED). Review of an ED note, dated 03/21/2023 at 2:24 AM, revealed Resident #143 presented to an ED from the facility via emergency medical services (EMS) on 03/20/2023 due to increased altered mental status and hyperglycemia. While with EMS, the resident's blood glucose remained severely elevated (over 500 mg/dL). A review of Resident #294's FACE SHEET revealed the facility admitted the resident on 05/19/2023 with diagnoses that included Diabetes. (continued on next page)

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Aspire Physical Recovery Center at Hoover, LLC	575 Southland Drive Hoover, AL 35226

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F 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of Resident #294's Physician Orders revealed orders, with date ranges of 05/23/2023-06/03/2023 and 06/03/2023-06/08/2023, for blood glucose checks three times daily. Resident #294 had a physician's order dated 05/19/2023 for . Humalog U-100 Insulin 100 unit/mL subcutaneous solution. GIVE SUB-Q [Subcutaneous] PER SLIDING SCALE ORDER 3 [three] TIMES DAILY BEFORE MEALS & BEDTIME FOR DM [Diabetes Mellitus]: 0-60=0 U [units] & [and] CALL MD [medical doctor]; 61-150=0 U; 151-200=2 u; 201-250=4 U 251-300=6 U; 301-350=8 U 351-400=10 U; >400 CALL MD/CRNP [Medical Doctor or Certified Registered Nurse Practitioner] Generic: INSULIN LISPRO .

A review of Resident #294's MAR, dated May 2023 and June 2023, revealed the blood glucose checks were not completed as ordered on ten occasions on the following dates and times:

-05/24/2023 at 9:00 PM

-05/25/2023 at 4:30 PM

-05/28/2023 at 4:30 PM

-05/31/2023 at 4:30 PM

-06/02/2023 at 6:30 AM

-06/06/2023 at 11:00 AM and 4:00 PM

-06/07/2023 at 11:00 AM and 4:00 PM

-06/08/2023 at 11:00 AM

During an interview on 06/02/2023 at 5:01 PM, LPN #19 indicated he checked resident MARs to determine and record which residents required blood glucose monitoring. He noted he obtained blood glucose values prior to administering insulin to residents. LPN #19 stated a MAR blank indicated the associated directive was not completed by staff.

During an interview with the Director of Nursing (DON) on 06/03/2023 at 5:14 PM, she stated she expected staff to follow physician orders.

During an interview with the Administrator on 06/03/2023 at 5:54 PM, he stated he expected staff to follow physician orders. He stated it was not acceptable to have blanks on medication sheets.

During an interview on 06/03/2023 at 4:46 PM, the Nurse Consultant (NC) indicated she recently conducted an in-service for medication aides regarding obtaining CBGs but was not sure if there was an in-service for nursing staff. The NC indicated it was important to obtain a diabetic resident's CBG because the resident could be hypoglycemic or hyperglycemic.

During an interview on 06/03/2023 at 5:20 PM, the DON indicated her expectation was for physician orders to be followed, noting if staff did not have time to pass medications or conduct monitoring tasks, the expectation was to ask for help. The DON stated that, for diabetic residents, the expectation was for the CBG to be measured and sliding scale insulin administered, if warranted. The DON identified that the importance of obtaining a CBG included recognizing severe hyperglycemia, which she noted could affect many body systems, and recognizing severe hypoglycemia, which could result from a

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NAME OF PROVIDER OR SUPPLIER: Aspire Physical Recovery Center at Hoover, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 575 Southland Drive Hoover, AL 35226	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident receiving too much insulin. The DON reported she was not aware that medication aides were obtaining CBG values from which nurses operated. During an interview on 06/03/2023 at 6:01 PM, the Executive Director (ED) indicated his expectation was for orders to be followed as written unless changed. The ED indicated it was not acceptable to have a blank on a MAR without a valid reason, which should be documented.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety 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, record review, facility document reviews, review of facility policies titled Medication Administration - General Guidelines and Documentation for Medication Administration, the facility failed to prevent significant medication errors for Residents #299 and #143, two of six residents reviewed for medication administration. The nursing staff failed to administer five morning doses of Resident #299's ordered anticonvulsant medication, Vimpat, from 05/26/2023 to 06/01/2023. On 06/04/2023 Resident #299 had a seizure and was transferred to a hospital for further treatment. In addition, the nursing staff failed to administer insulin as ordered for Resident #143. On 03/20/2023, Resident #143 was found to have a blood glucose level greater than 500 milligrams per deciliter (mg/dL) and was transferred to an emergency department. Failure to administer insulin as ordered creates a likelihood of unusually high (hyperglycemia) blood glucose levels which can potentially lead to life-threatening conditions, both acute and chronic. It was determined the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, §483.45(f)(2) Residents Are Free of Any Significant Medication Errors at a scope and severity of J. On 06/23/2023 at 8:18 PM the Executive Director, the Director of Nursing, the Assistant Director of Nursing, and the Nurse Consultant were provided a copy of the immediate jeopardy template and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Pharmacy Services, at F760-Residents Are Free of Significant Med Errors. The immediate jeopardy began on 03/20/2023 and continued until 06/25/2023, when the facility implemented corrective actions to remove the immediacy and prevent further recurrences. Findings included: A review of the facility's policy titled, Medication Administration - General Guidelines, dated April 2020, revealed, .Medications are administered in accordance with written orders of the attending physician . A review of the facility's policy titled, Documentation for Medication Administration, dated April 2020, revealed, .At the end of each medication pass, the person administering the medications reviews the MAR [medication administration record] to ensure necessary doses were administered and documented . 1. A review of Resident #299's FACE SHEET revealed the facility admitted the resident on 05/26/2023 at 3:36 AM with diagnoses that included Metabolic Encephalopathy and Myoclonus (brief, involuntary, irregular twitching of a muscle, a joint, or a group of muscles). A review of Resident #299's Care Plan(s), with a start date of 05/26/2023, revealed the resident had a potential for seizures. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #299's [Facility name] admission History and Physical, dated 05/27/2023, revealed the resident had an abnormal electroencephalogram (EEG - a test that measured electrical activity in the brain) with facial twitching prior to admission to the facility. Per the document, the resident was placed on antiepileptics (a type of drug used to prevent or treat seizures or convulsions by controlling abnormal electrical activity in the brain) and the twitching resolved. The ASSESSMENT/PLAN indicated Resident #299 had myoclonic seizures and was to continue their Vimpat (an anticonvulsant; also called an antiepileptic medication used to treat partial seizures). A review of Resident #299's Physician Orders List indicated on 05/26/2023, the resident received an order for Lacosamide (Vimpat, an anticonvulsant medication)100 milligrams (mg), administer one tablet orally twice a day for seizures. A review of Resident #299's MAR for May 2023, revealed Lacosamide was scheduled to be administered each day at 9:00 AM and 9:00 PM. Review of the MAR revealed the 9:00 AM dose of Lacosamide was not administered on 05/26/2023, 05/27/2023, 05/28/2023 and 05/29/2023. A review of Resident #299's MAR for June 2023 revealed the 9:00 AM dose of Lacosamide was not administered on 06/01/2023. A review of the Controlled Drug Record for Resident #299's Lacosamide 100 mg revealed the facility received 30 tablets from the pharmacy on 05/25/2023. The Controlled Drug Record confirmed there no were doses of Lacosamide signed out for 9:00 AM on 05/26/2023, 05/27/2023, 05/28/2023, 05/29/2023, or 06/01/2023. A review of Resident #299's Departmental Notes, dated 05/26/2023 - 06/04/2023, revealed there was no documentation related to the administration or lack of administration of the resident's ordered medication, Lacosamide. A review of Resident #299's Departmental Notes dated 06/04/2023 at 3:23 PM, indicated Resident #299 had a seizure around 2:50 PM and an ambulance was called due to the progression of the resident's seizure. The Departmental Note indicated by the time the ambulance was called, Resident #299 had seized for approximately ten minutes, and the paramedics arrived and took over at the 18-minute mark. The resident was still seized at the 25-minute mark and was transferred to the hospital for further evaluation. During an interview on 06/20/2023 at 11:35 AM, the Director of Nursing (DON) stated the facility found that the seizure medication was not given after reviewing the resident's chart during the interdisciplinary team meeting. The DON also stated she knew RN #26, RN #12, and RN #22 worked the medication cart in the time that the medication was not administered. During an interview on 06/20/2023 at 11:04 AM, RN #26 stated it was her first week of work in the facility during the time Resident #299 missed their seizure medication. RN #26 stated she did not have the keys to the medication cart and shadowed other nurses at the time. During an interview on 06/20/2023 at 12:16 PM, RN #12 stated she had not administered medications to Resident #299. In an interview on 06/25/2023 at 12:47 PM, RN #12 stated when a nurse took the keys to a medication cart, the nurse assumed responsibility for the residents assigned to that medication cart, to (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	include ensuring the residents' medications were administered as ordered by the physician. During an interview on 06/20/2023 at 4:10 PM, LPN #24 stated on the morning of 05/27/2023, she counted the medication cart for the 200 hall with the off-going nurse and then went to the 300 hall to work until the ADON came in to work. Per LPN #24, she was not aware that she had missed the administration of Resident #299's seizure medication. During an interview on 06/20/2023 at 4:17 PM, the ADON stated she came to work around 10:30 AM on 05/27/2023 and took the keys to the medication cart from LPN #24. The ADON stated she would not have administered Resident #299's seizure medication since she was not in the facility when the medication was due to be administered. In a follow-up interview on 06/20/2023 at 4:28 PM, the DON confirmed Resident #299's Lacosamide medication was delivered to the facility on [DATE] and was available for administration on 05/26/2023. The DON stated the medication should have been administered and she did not know why the medication was not administered. During an interview on 06/23/2023 at 10:40 AM, the Pharmacy Consultant stated it was important for the resident to receive their seizure medication to prevent seizures or to decrease the frequency of seizures. The Pharmacy Consultant stated if a resident missed several morning doses and received the evening doses of their seizure medication, the missed doses could contribute to the resident experiencing a seizure since some residents have break through seizures when their medications are administered as ordered. According to the Pharmacy Consultant, she could not rule out the cause of Resident #299's seizure on 06/04/2023 was a result of the missed doses of Lacosamide. During an interview on 06/20/2023 at 11:57 AM, the Medical Director stated he expected the staff to administer a resident's medications as ordered. 2. A review of Resident #143's FACE SHEET revealed the facility admitted the resident on 03/16/2023 with diagnoses that included Type Two Diabetes Mellitus with Diabetic Chronic Kidney Disease. A review of Resident #143's care plan with a start date of 03/17/2023, revealed the resident had a potential for complications related to Diabetes. The care plan directed staff to administer the resident's medications as ordered for Diabetes. A review of Resident #143's Medication Orders revealed on 03/16/2023, the resident was ordered Semglee pen 100 units per milliliters (unit/ml), administer nine units subcutaneous at bedtime for Diabetes Mellitus and Insulin Aspart 100 unit/ml, inject three units three times a day subcutaneous with meals for Diabetes Mellitus. A review of Resident #143's MAR [medication administration record] for March 2023, revealed the order for Insulin Aspart was scheduled to be administered each day at 6:30 AM, 11:30 AM, and 4:30 PM. The MAR indicated the Insulin Aspart was not administered on 03/18/2023 at 11:30 AM. There was no evidence the Insulin Aspart was administered at 6:30 AM dose on 03/19/2023, 03/20/2023, and 03/21/2023. There was no evidence the 8:00 PM dose of Semglee was administered on 03/18/2023. A review of Resident #143's Departmental Notes, written by Licensed Practical Nurse (LPN) #16 and dated 03/20/2023 at 10:57 PM, indicated the nurse went into Resident #143's room to check their blood sugar. Per the note, the resident stood in front of the television unsteadily. When LPN #16 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assisted Resident #143 to the chair, the resident started to shake, and the resident reported they were unable to keep their eyes open. LPN #16 checked the resident's blood sugar, and the reading was 537 milligrams per deciliter (mg/dL). The note indicated Resident #143's vital signs were unstable, with a blood pressure reading of 78/48 milligrams of mercury (mmHg) and heart rate of 112 beats per minute. Hospice was contacted and gave orders to send the resident to the emergency department (ED). The American Diabetes Association's goals for blood sugar control in people with diabetes are 70 to 130 mg/dL before meals, and less than 180 mg/dL after meals. A review of an ED Note, dated 03/21/2023 at 2:24 AM, revealed Resident #143 presented to the ED by emergency medical services (EMS) on 03/20/2023 at 9:54 PM from the facility because of altered mental status and an elevated blood glucose level (hyperglycemia). According to the note, the resident had an elevated glucose reading of over 500 mg/dL with EMS. During an interview on 06/01/2023 at 11:22 AM, Resident #143's family member (FM) stated Resident #143's blood sugar had never been that high in four years. Per the FM, they felt the facility did not give the resident their medication. During an interview on 06/02/2023 at 7:08 AM, LPN #16 confirmed on 03/20/2023 she observed Resident #143 stand unsteady in front of their television. LPN #16 indicated she yelled for the staff to assist her get the resident settled into a chair. LPN #16 stated when additional staff came to assist, the resident was assessed and then transported to the ED for further evaluation. During an interview with the Nurse Consultant (NC) on 06/03/2023 at 4:36 PM, she stated she expected the staff to administer medications as ordered by the physician. The NC said if resident did not receive their insulin, it could result in an elevated blood glucose level, which could cause issues for the residents. During an interview with the Director of Nursing (DON) on 06/03/2023 at 5:20 PM, she stated she expected the staff to follow the physician's orders. During an interview with the Administrator on 06/03/2023 at 6:01 PM, he stated he expected the staff to follow the physician's orders and give medication as ordered. During an interview on 06/23/2023 at 10:40 AM, the Pharmacy Consultant stated it was important for residents to receive their insulin as ordered. She indicated when a resident did not receive their insulin as ordered, there could be various outcomes for the resident, dependent on how controlled the resident's blood glucose levels were. The Pharmacy Consultant indicated Resident #143's Insulin Aspart was short-acting, and the Semglee was long-acting. She explained once the Semglee reached the dose required, it stayed at a steady level in the bloodstream to control blood glucose levels over a longer period. According to the Pharmacy Consultant, a dose of the Semglee should be administered unless specifically ordered by the doctor. This deficiency was cited as a result of complaint/report #AL00042084, #AL00043844, and #AL00044419 ** F760-The facility failed to ensure a seizure medication was administered as ordered to [Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2023
NAME OF PROVIDER OR SUPPLIER Aspire Physical Recovery Center at Hoover, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 575 Southland Drive Hoover, AL 35226	

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#299], which resulted in a significant medication error. 1. [Resident #299] was sent to the ER [emergency room] and physician notified. Resident was admitted to hospital on [DATE]. 2. A review was completed on 06/23/2023 by the DON [Director of Nursing] of 15 of 15 guests that require seizure medication to ensure that medications had been administered per physician orders. The Nurse Practitioner was notified of one guest that refused doses of their seizure medication and new orders were obtained. A daily review of all medications, that started on 06/23/2023 and will continue daily, will be done to ensure that all medications have been administered per physician orders. Any discrepancies will be reviewed with MD/CRNP [Medical Director/Certified Registered Nurse Practitioner] daily, re-education will be provided, and monitoring will continue as needed. Daily review of all medications administered will be conducted by the DON or designee. 3. Education of the medication administration policy specifically, Medications are administered in accordance with written orders of the attending physician, was started on 06/05/2023 to all Licensed Nursing Staff and MACs [medication administration, certified] by the DON or Designee, including night shift, to ensure medications were administered per physician orders. The Licensed Nurses identified with the missed medication error were given one on one education and training by the DON prior to their next shift worked that included acknowledgement of responsibility of medication administration once medication cart keys are accepted. All fulltime, part time, and PRN staff will be educated prior to beginning work on their next shift by the DON or designee. 4. An emergency QAPI [quality assessment performance improvement] was held on 06/05/2023 concerning the administration of seizure medications to guest and the daily reviews of the medications will be submitted to the QAPI committee for continuing compliance. Any discrepancies identified will be immediately corrected through re-education of Licensed Nursing Staff and continued daily reviews of medication administration. F760-The facility failed to ensure insulin was administered according to Physician orders for Resident #143 1. Residents #143 have discharged from the facility with no adverse effects. CRNP was notified of findings on 06/24/2023. 2. A review was completed on 06/03/2023 by RN [registered nurse] of 11 of 11 guests that require the use of insulin to ensure Physician Orders did not prompt insulin administration outside parameters (CBG [capillary blood glucose] and Sliding Scale attached to order). On 06/19/2023 a review was conducted by LPN [licensed practical nurse] of all diabetic residents that ensured that all orders were correct and on MAR [medication administration record] correctly (to include CBG, site administered, and Unit dose required). A daily review of all guests that require the use of insulin was started on 06/05/2023 to ensure administration, CBG obtained, and insulin dose per sliding scale of physician orders was conducted by the DON or designee and will be on-going. Any discrepancies will be reviewed with MD/CRNP daily, re-education completed, and continued monitoring as needed. 3. Education on medication administration started on 06/05/2023 to all Licensed Nursing Staff, including night shift, by DON or Designee to ensure Insulin was being administered per physician orders (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Obtain CBG and dose Sliding Scale per Physician Orders) prior to beginning work on their next shift. Also, education was provided by the DON or designee to all Licensed Nursing Staff, including night shift, on how to accurately enter CBG and Sliding Scale Insulin Orders to ensure CBG was recorded, and insulin was dosed per Sliding Scale orders. All fulltime, part time and PRN [as needed] licensed staff will be educated prior to beginning work on their next shift. The DON or designee will also conduct mock competency validations to obtain CBG, record the reading, draw up and administer insulin per sliding scale and document with all Licensed Nursing Staff beginning on 06/25/2023. Licensed Nursing Staff will be provided with a random number and a sliding scale to determine how many units must be given. Once the required dose of insulin is determined, the nurse will use an insulin syringe and a vial of 0.9% sodium chloride injection, USP to demonstrate how to pull up the insulin for administration according to the provided sliding scale. The nurse will administer the appropriate amount of insulin into an orange. All Licensed Nursing Staff will complete the competency prior to the next shift worked. 4. Results of the daily reviews of all guests that require the use of insulin will be submitted to the QAPI committee monthly and reviewed for continuing compliance. Any discrepancies identified will be immediately corrected through re-education of Licensed Nursing Staff and continued daily reviews of guests that require the use of insulin. 5. All corrections were completed on 06/25/2023. 6. The immediacy of the IJ was removed on 06/25/2023. ********** After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F760 was lowered to a lower scope and severity of no actual harm with an isolated potential for more than minimal harm that was not immediate jeopardy on 06/25/2023, to allow the facility time to monitor and/or revise their corrective actions as necessary to ac

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, the facility policy titled, Incidents and Accidents, and interviews, the facility failed to maintain medical records for residents that were complete and accurately documented for two (Resident #141 and Resident #106) of 27 sampled residents. Specifically, 1) the facility failed to document the administration of medications for Resident #141. 2) the facility failed to complete an incident report when Resident #106 was found on the floor on 04/18/2023. Findings included: 1) A review of Resident #141's FACE SHEET revealed the facility admitted the resident on 03/15/2023 with diagnoses that included Aftercare Following Joint Replacement Surgery, Anxiety Disorder, Hypertension, Gastro-esophageal Reflux Disease (GERD), and Hypokalemia (low potassium). A review of the five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/22/2023, revealed Resident #141 was independent with daily decision making according to the Staff Assessment for Mental Status. The resident was independent with eating and personal hygiene; required supervision from staff with set-up help only for transfers, walking in the room or corridor, and toilet use; limited assistance of one person for bed mobility, locomotion on and off the unit; extensive assistance from staff for dressing, and the resident required physical help for part of the bathing activity. The MDS indicated the resident had a surgical wound. A review of Resident #141's Care Plan, dated 03/16/2023, indicated the resident had a surgical incision/wound related to a right total knee arthroplasty (TKA). The Care Plan instructed the staff to assess wound healing weekly, do full skin evaluations with a bath or shower, assess the skin daily with routine care, assess and treat pain if present, reduce incisional pressure with position changes, encourage good nutritional intake, and assess changes in skin status that indicate worsening of the surgical wound and notify the physician. A review of Resident #141's March 2023 Physician Orders indicated the following medications were ordered to be administered to the resident beginning 03/15/2023: - Ascorbic Acid (vitamin c) 1,000 milligram (mg) tablet, give one tablet by mouth daily for a supplement. - Cholecalciferol (vitamin D3) 25 microgram (mcg) (1,000 unit) tablet, give one tablet by mouth daily for a supplement. - Thera-M (multivitamin) 27 mg-0.4 mg tablet, give one tablet by mouth daily for a supplement. - Omega-3 Fish Oil 300 mg-1,000 mg capsule, give two capsules by mouth daily for a supplement. - Potassium Chloride ER (extended release) 8 milliequivalent (meq) tablet, give one tablet by mouth (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily for a supplement. - Methocarbamol 500 mg tablet every six hours for muscle spasms. - Benefiber Sugar Free (a natural fiber) 3 grams/4 grams oral powder. Administer 10 milliliters by mouth twice daily. - Triamterene - Hydrochlorothiazide (HCTZ) 37.5- 25 mg tablet, give one tablet by mouth daily for hypertension. A review of Resident #141's March 2023 MAR [Medication Administration Record] revealed N was documented for the doses of ascorbic acid, cholecalciferol, Thera-M, Omega-3 fish oil, and potassium chloride on 03/22/2023 and 03/23/2023. In addition, an N was documented for the 8:00 AM dose of HCTZ on 03/22/2023 and there was no documentation (blank) for the 8:00 AM dose of HCTZ on 03/23/2023. Further, N was also documented for the 8:00 AM dose of Benefiber on 03/23/2023. Per the MAR, a N indicated the medication was not administered. A further review of Resident #141's March 2023 MAR [Medication Administration Record] revealed the 12:00 AM doses for methocarbamol 500 mg on 03/23/2023 and 03/24/2023 were blank, and there was no documentation the medication was administered. A review of the Administration Record and Departmental Notes notes for the month of March 2023 revealed no documented explanation about the medications not being administered. During an interview on 06/01/2023 at 3:03 PM, Registered Nurse (RN) #12 stated if there was a blank on residents' MARs, it meant either the staff person did not document it, or it was not given. During an interview on 06/02/2023 at 3:30 PM, Licensed Practical Nurse (LPN) #11 stated if there was a blank on a MAR, the medication was not given, or the staff person gave the medication but did not document that it was given. During an interview on 06/03/2023 at 9:55 AM, Unit Manager (UM) #8 stated a blank on the MAR record indicated the medication was either not given or staff did not document the medication was administered. During an interview on 06/03/2023 at 5:15 PM, the Director of Nursing (DON) stated if there were blanks on the MAR then the medication was not given. During an interview on 06/03/2023 at 5:56 PM, the Executive Director (ED) stated there should be no blanks on the MAR without a documented reason. An interview with the Nurse Consultant on 06/03/2023 at 4:36 PM revealed if there was a blank on a MAR, staff had cleared the medication so they could see what other medications needed to be administered. She stated the risk of clearing a medication was if the medication had not been given, staff would not know it still needed to be administered. She stated staff had been educated not to clear the system. 2) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Incidents and Accidents, effective 11/10/2014, revealed, .An incident is an occurrence that may not be consistent with the routine operation of the facility or the routine care of a particular resident/guest. Per the policy, b) An Incident/Accident report should be completed . A review of Resident #106's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/20/2023, revealed the facility admitted Resident #106 on 04/13/2023 with diagnoses that included Alzheimer's disease and atrial fibrillation. The Staff Assessment for Mental Status revealed Resident #106 had moderately impaired cognitive skills for daily decision making, The MDS also revealed the resident required supervision (set-up help only) with bed mobility, transfers, walking in the room and corridor, dressing, toilet use, and personal hygiene and limited assistance with bathing. The MDS further revealed the resident utilized a walker for mobility and was not steady while walking, moving on and off the toilet, and transferring from surface to surface. The MDS indicated, the resident had one fall with injury, not major since admission. A review of Resident #106's Care Plan(s), dated 04/14/2023 revealed the resident had a potential for falls related to impaired mobility, weakness, and the use of multiple medications. Interventions directed staff to assist with ambulation, toileting and mobility as needed; observe for the need for additional assistive devices; review the toileting program as needed; and encourage a clutter free environment and path to the bathroom. A review of Resident #106's Departmental Notes dated 04/18/2023 at 7:50 AM, revealed a certified nursing assistant responded to Resident #106's yell for help and found the resident on the floor in their room with a skin tear on their left elbow. Review of the resident's medical record did not reveal an incident report related to the fall the resident had on 04/18/2023. During an interview on 06/03/2023 at 8:06 AM, the Director of Nursing (DON) stated when a resident fell, the nurse should complete an incident report after assessment of the resident. During an interview on 06/03/2023 at 4:44 PM, the Nurse Consultant (NC) stated an investigation should have been completed after each fall to determine the cause or causes of the fall. During an interview on 06/0320/23 at 5:59 PM, the Executive Director (ED) stated after a fall, he expected staff to investigate and assess the resident for injury and notify the family and the physician. He stated he also expected staff to follow up and determine a root cause of the fall so that interventions could be put in place to prevent further falls. This deficiency was cited as a result of complaint/report #AL00043725.