Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0041	A. BUILDING: ______ B. WING ______	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

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R 000	Initial Comments On 06/26/2022, the District of Columbia Health Regulation (DC Health's) Intermediate Care Facilities Division received an anonymous complaint regarding concerns for the health and safety of the residents currently living at Livingston Place Assisted Living Residences (ALR). Due to the nature of the allegations, the State Survey Agency (SSA) initiated an on-site investigation on 06/29/2022 through 07/12/2022 to determine compliance with the Assisted Living regulations and the Assisted Living Law "DC Code § 44-101.01". The ALR is licensed for a total capacity of one hundred and fifty-three (153) residents. The current census 93 residents and seven (7) residents who were away from the facility. In addition, the Acting Assisted Living Administrator informed the survey team that four new residents were expected to be admitted in the month of July 2022. A total of 19 [17 current resident records and two newly admitted residents] were reviewed. The complainant alleged the following: 1. "Resident #2 continued to receive her old dose of Trulicity [Diabetic medication] after it was increased to 1.5 mg every week on 03/23/2022. The ALR did not change the order until 04/14/2022." Conclusion: Substantiated 2. "Resident #3 never started on Rosuvastatin [hypercholesterolemia] that was ordered March 2022 and never received her Levaquin and	R 000	Please start typing your responses here:	

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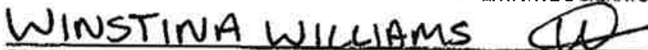
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: WINSTINA WILLIAMS 

TITLE: EXECUTIVE DIRECTOR (X6) DATE: 9/16/22

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R 000	Continued From page 1 Linezolid on 04/11/2022 as ordered." Conclusion: Substantiated 3. "Resident #4 received Iron tablets five times daily instead of the three times a day and then twice a day after one month as ordered." Conclusion: Substantiated 4. "Resident #5 did not receive her prescribed medication of Levothyroxine [hypothyroidism] from 05/03/2022 through 05/10/2022, 05/12/2022 and 05/13/2022." Conclusion: Substantiated 5. "Nurses not knowing what medications they are administering when asked by the patient or patient family. Conclusion: Not substantiated 6. "Resident #6's family reported that the resident did not receive her medications on a Monday (date not given) and when they notified the nurse, she said that they (the nurse) would be on a different floor for the evening medication pass." Conclusion: Substantiated 7. "Resident #7 did not get her medications for one to three days after her return from the hospital." Conclusion: Substantiated 8. "Nurses were not assessing the resident's vital signs, weights, B/P and glucose monitoring as ordered."	R 000	**1. Due to the time of missed medication and treatment unable to correct. However, resident medication orders have been reviewed and corrected as needed.** **2. Medication administration audits are conducted to ensure medication are received in a timely manner. Licensed nurses were in-serviced on the "8 Rights of Medication Administration". Medication observations performed with the licensed staff to ensure proper medication administration.** **3. Medication Administration Audit" report will be review in the Morning meeting. The results of the audit will be documented in PCC. Staff will be in-serviced as well as disciplined if there is evidence of repeated infractions. Reports of the Audit will be reviewed in the Quality Assurance Performance Improvement (QAPI) Committee Meetings**	

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R 000	Continued From page 2 Conclusion: Substantiated 9. "Resident #9 missed several days/weeks of her Diabetic medications since refills were sent to the former Primary Care Physician, who stated the resident was no longer under their care." Conclusion: Partially substantiated 10. "Resident #10 had orders for Seroquel [Antipsychotic medicine] be administered on Saturdays, but the nurses never administered the medication." Conclusion: Not substantiated 11. "Resident #1 had trouble receiving some of his medications as one nurse is covering two floors." Conclusion: Substantiated 12. "Nurses were not administering medications in accordance with the physician's orders." Conclusion: Substantiated 13. "There were delays in the residents receiving their medications." Conclusion: Substantiated 14. "Residents were being admitted without determining their health status [tuberculosis (TB)]." Conclusion: Substantiated 15. "There was a delay in a resident receiving the	R 000		

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R 000	Continued From page 3 proper care because the nurses did not know the signs and symptoms of a stroke.' Conclusion: Substantiated 16. "Resident #11 had an order for Azithromycin (Z-Pack) on 5/11/2022 and never received the medication." Conclusion: Not Substantiated 17. Direct Care Nurses were informed about Resident #13's burn wound and did not report it to the Nurse Practitioner or Registered Nurse, resulting in a delay in the proper treatment of the wound. Resident #13 did not receive prescribed Bactrim. Conclusion: Partially Substantiated 18. The ALR nursing staff performed a COVID PCR swab on Resident #10, placed the swab in the Lab Corp box and failed to call Lab Corp for pick-up. Conclusion: Substantiated The investigative findings were based on observations, interviews with the complainant, direct care staff, management staff, residents, family member and review of administrative and clinical records. The investigation determined that the ALR failed to be in compliance Assisted Living Regulations and the Assisted Living Law "DC Code § 44-101.01". The deficient practices are addressed throughout this report.	R 000		
R 292	Sec. 504.1 Accommodation of Needs.	R 292		

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(1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents.

Based on interviews, and record reviews, the Assisted Living Administrator (ALA) failed to ensure that each resident received: (I) prescribed drugs in accordance with the physician's orders, (II) timely wound care services, (III) appropriate emergency services, and (IV) other treatment services, for 12 of the 17 residents sampled (Residents #1, 3, 5, 6, 7, 8, 9, 10, 11, 13, 14, and 15).

Findings included:

I. The facility failed to ensure that each resident's medications were administered in accordance with the physician's orders, as evidenced below:

A. On 06/29/22, beginning at 12:00 PM, review of Resident #1's Physician Order Sheet (POS) dated April 2022 revealed that Resident #1 was prescribed Eliquis [anticoagulant medication] 5 mg twice a day. At 12:09 PM, a review of Resident #1's Medication Administration Record (MAR) revealed that Eliquis was not administered to the resident on 04/08/2022 and 04/11/2022 during the morning medication administration and during the evening medication administrtaion on 04/01/2022, 04/04/2022 and 04/10/2022.

Beginning at 2:00 PM, review of Residents #1's progress notes dated 04/01/2022, 04/10/2022 and 04/11/2022 revealed the nurse documented "call made to pharmacy." The 04/04/2022 nursing note stated, "Awaiting pharmacy delivery." On 04/08/2022, a nurse wrote Eliquis was "on order yet to be delivered."

Accommodation of needs

1. **Residents medical record were reviewed to ensure no further infractions had occurred and corrected as needed. A new scale was assembled; resident weights obtained as ordered.**
2. **Staff in-serviced/trained on the proper procedure for Medication administration and Documentation. Individual training will be implemented as needed. Medication Audit will continue, and results will be reported in Morning meeting.**
3. **Medication Administration Audit" report will be review in the Morning meeting. The results of the audit will be reviewed /in PCC. Staff will be In-serviced as well as disciplined if there is evidence of repeated infractions. Reports of the Audit in the Quality Assurance Performance Improvement (QAPI) Committee Meetings**

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B. On 06/29/2022 beginning at 12:00 PM, review of Resident #1's POS dated April 2022 revealed that Resident #1 was prescribed Pregabalin [nerve pain medication] 50 mg three times a day. At 12:09 PM, Resident #1's MAR showed that Pregabalin was not administered to the resident on 04/16/2022, 04/17/2022 and 04/18/2022 during the morning medication administration. The Pregabalin also was not administered on 04/15/2022, 04/16/2022, 04/17/2022 and 04/18/2022 during the midday and evening medication administrations.

Beginning at 2:00 PM, review of Resident #1's progress notes dated 04/15/2022 revealed the nurse documented that the medication was "on order." Nursing notes dated 04/16/2022 and 04/17/2022 read "Needs new script, awaiting pharmacy delivery." A nursing note dated 04/18/2022 showed the Pregabalin "not available, yet to be delivered."

C. On 06/29/2022 beginning at 12:00 PM, review of Resident #1's POS dated May 2022 revealed that Resident #1 was prescribed Trulicity [diabetic medication] 0. 5 ml once a week. At 12:09 PM, a review of Resident #1's MAR revealed that Trulicity was not administered to the resident on 05/06/2022 during the morning medication administration.

Beginning at 2:00 PM, review of Resident #1's progress note dated 05/06/2022, revealed the nurse documented that the medication was "on order."

D. On 06/29/2022 beginning at 12:00 PM, review of Resident #1's POS dated May 2022 revealed that Resident #1 was prescribed Vitamin D3

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R 292	Continued From page 6 50,000 units once a week. At 12:09 PM, a review of Resident #1's MAR revealed that Vitamin D3 was not administered on 05/22/2022 as scheduled during the morning medication administration. Beginning at 2:00 PM, review of Resident #1's progress note dated 05/22/2022, showed the nurse documented "Medication not available." E. On 06/29/2022 beginning at 12:00 PM, review of Resident #1's POS dated June 2022 showed Resident #1 was prescribed Bevespi Aerosphere [respiratory inhaler] 9-4.8 mcg twice a day. At 12:09 PM, a review of Resident #1's MAR showed Bevespi Aerosphere was not administered on 06/20/2022 and 06/22/2022 during the morning medication administrations. Beginning at 2:00 PM, review of Resident #1's progress note dated 06/20/2022, showed the nurse documented the medication was "on order." A progress note dated 06/22/2022 stated "on delivery." F. On 06/29/2022 beginning at 2:45 PM, review of Resident #14's POS dated May 2022 showed Resident #14 was prescribed Memantine [memory enhancing medication] 5 mg twice a day. At 3:05 PM, a review of Resident #14's MAR showed that Memantine was not administered on 05/13/2022 and 05/16/2022 during the evening medication administrations. Beginning at 3:30 PM, review of Resident #14's progress notes dated 05/13/2022, showed the nurse documented "New script stated the med is in another package script." A progress note dated 05/16/2022 showed "This med was shipped in separate workflow strip or sent to backup	R 292		

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pharmacy. Call made to pharmacy."

G. On 06/29/2022 beginning at 2:45 PM, review of Resident #14's POS dated May 2022 showed that Resident #14 was prescribed Pravastatin [anti-hypercholesterolemia medication] 10 mg daily. At 3:05 PM, a review of Resident #14's MAR showed that Pravastatin was not administered on 05/16/2022 during the morning medication administrations.

Beginning at 3:30 PM, review of Resident #14's progress note dated 05/16/2022 showed the nurse documented "call made to pharmacy."

H. A review of Resident #5's April 2022 MAR showed no evidence that her blood glucose level was checked at 6:00 PM on 04/16/2022, with no Novolog insulin coverage administered, accordingly. There were no progress notes to provide any explanation why the residents blood sugar was not checked on that day.

I. Resident #5 did not receive the full 10-day regimen of Ciprofloxacin (Antibiotic medication) HCL 500 mg twice daily, beginning 04/07/2022. The resident did not receive the last three doses of Ciprofloxacin of the 20-dose prescription ordered by the physician.

On 06/30/2022 beginning at 2:29 PM, the DON acknowledged the findings in the resident's Mars. She stated that she had been training the nurses on maintaining accurate documentation. She was unable to provide a record of the said trainings. Earlier, at 11:29 AM, the DON had informed surveyors that there was no documentation available for review to show that staff received training prior to her being hired in April 2022

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J. The complainant alleged that Resident #6's family reported that the resident did not receive medications on a Monday (date not provided). These medications included: [Metformin 1000 mg for diabetes mellitus, Pantoprazole 40 mg tab for stomach ulcer, Primidone, 50 mg tab for hypertension, Atorvastatin 20 mg, tab for high cholesterol, Donepezil 10 mg, cognitive impairment, and Metoprolol 100 mg, hypertension]. Review of Resident #6's MARs showed that the resident did not receive morning medications on 04/01/2022, 04/02/2022, 04/04/2022, 05/10/2022 and evening medications from 04/01/2022 through 04/04/2022 and 05/10/2022. There were no progress notes available to explain why these medications were not administered.

K. [Cross-reference R373(Law)] A review of Resident #6's progress notes showed that the resident was to begin a 10-day treatment with Bactrim antibiotic twice daily. The facility nurses documented the administration of Bactrim on 04/28/2022 and 04/29/2022. There was no evidence that Resident #6 received the Bactrim on the remaining eight days (16 doses of antibiotics medications were omitted without reason).

L. On 6/30/2022 at 1:37 PM, review of Resident #3's hospital discharge summary dated 04/8/2022 showed diagnoses that included left lower extremity cellulitis and bilateral leg edema. While in the hospital, the resident was prescribed Levofloxacin (antibiotic medication) 750 mg by mouth daily and Linezolid (antibiotic) 600 mg every 12 hours by mouth, which were to be continued at the assisted living residence (ALR) until 04/13/2022. Continued review of Resident #3's April 2022 MAR however, lacked evidence

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that any further doses of the two antibiotic medications (last four doses of the ten-day cycle) were administered after the initial doses that were administered in the hospital.

M. On 6/30/3022, at 11:57 AM, a review of Resident #3's record showed a physician order dated 3/2/2022 for Rosuvastatin 20 mg tab, one tab every evening for Hyperlipidemia. There was an order dated 3/17/2022, to discontinue the medication. Continued review of both the MAR and the nurse progress notes from 3/02/2022 to 3/17/2022 showed no documented evidence that the resident received the Rosuvastatin 20 mg tab medication as ordered by the physician, which was to have been started on 03/02/2022.

N. A review of Resident #10's record showed a physician's order dated May 23, 2022, for Januvia 50 mg daily for 5 days beginning 05/26/2022 for elevated blood glucose level of 500 mg/dl and hemoglobin A1c of 12.2. Further review of the MAR showed no evidence that Resident #10 was administered the medication for five days as ordered.

O. [Cross-reference R373] Resident #7 was discharged from the hospital 05/19/2022 with a diagnosis of Urinary Tract Infection (UTI). The resident returned to the facility with a prescription for Macroban (antibiotic)100 mg capsule, 1 cap twice a day x 5 days by mouth daily. According to progress notes, the resident received the antibiotic on 05/19/2022 and 05/20/2022. Continued review of the progress notes showed no additional documentation that the resident received the Macroban for the next three days (05/21/2022, 05/22/2022 and 05/23/2022).

On 06/29/2022 at 4:27 PM, interview with the

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Director of Nursing (DON) revealed that orders are not always timely when not made through the facility's pharmacy portal.

On 07/01/2022 beginning at 12:24 PM, the DON said during an interview that the nursing staff administering medications were to document the medications administered on the MARs. When the surveyor showed the DON the missing documentation on June 2022, May 2022, and April 2022 MARs, the DON responded by saying, "you're right, the documentation isn't there." The DON did not offer any reasons as to why the medications were not documented on the MAR. She stated that she would re-educate the nursing staff on medication administration documentation.

At the time of the investigation, the facility failed to ensure each resident's right to receive all prescribed drugs in accordance with physician's orders.

II. The ALR failed to ensure timely assessment and treatment of a resident that sustained a burn injury, as evidenced below:

[Cross-reference to R483] The complainant alleged that Resident #13 sustained a second degree burn and was not receiving treatment. During an interview with the ALR's Nurse Practitioner (NP) on 06/29/2022 starting at 10:14 AM, she indicated that on 05/25/2022, Resident #13 informed her that she spilled coffee on her leg two days prior and had sustained a burn and asked if she should go to the emergency room. The NP assessed the resident's thigh and determined that the resident had sustained a second-degree burn. The NP gave an order for the nurses to cleanse the wound with Normal Saline, pat dry, and apply Silvadene (topical

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antimicrobial drug) twice a day.

On 06/29/2022, at 4:00 PM, the DON during interview acknowledged that Resident #13 reported the injury to two nurses who failed to take appropriate action. The DON stated that both nurses were terminated.

At the time of the investigation, the ALR failed to ensure Resident #13 received timely assessment and treatment following a burn injury.

III. The ALR failed to ensure residents received emergency services, as evidenced below:

A. On 06/29/2022 beginning at 12:54 PM, the Nurse Practitioner (NP) said during an interview that she was informed on 06/26/2022 that Resident #8 was taken to the emergency room for a stroke at 7:00 PM on the night before (06/25/2022). The NP further stated she did not know how long the resident was exhibiting signs and symptoms of stroke prior to the call for 911/Emergency Medical Services (EMS). According to the hospital discharge summary, the patient was outside the window for tissue plasminogen activator [tPA].

On 06/29/2022 at 3:00 PM, during an interview, LPN #1 stated that Resident #8 informed her on 06/25/2022 that he felt like he was having a stroke. LPN #1 assessed the resident's vital signs which she stated were within normal limits. Resident #8 then called his family members in North Carolina (early morning) to inform them that he thinks he is having a stroke. The family in North Carolina then called a local family member who eventually came to the facility later that day. The local family member requested that the ALR nurse call 911 due to slurred speech and left side

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weakness. LPN #1 acknowledged that she did not document the time that EMS arrived, nor did she document the time that EMS took the resident to the emergency room.

B. According to the NP, on 06/18/2022, LPN #6 called her three times regarding Resident #15. At 3:57 PM the nurse informed the NP that the resident was "... A little confused and did not feel good." the nurse was not able to provide more information to the NP. At 6:44 PM the LPN #6 called the NP and informed her of the urine dipstick results and that the resident was trying to eat a sandwich but was not using her hands. At 8:01 PM the LPN #6 called the NP to inform her that the paramedics was concerned that the resident may be having a stroke. The NP stated that she asked the LPN if the resident was having weakness on her left side, to which the LPN responded, "I think it got worse." The NP further stated that she asked the LPN if she performed a neurological assessment, to which LPN #6 admitted that she had not performed an assessment.

At the time of the investigation, the ALR failed ensure the resident's right to receive timely assessment and treatment when showing signs of stroke.

IV. The ALR failed to ensure that residents received ancillary services as ordered (weights, vital signs, glucose monitoring, and supplemental oxygen), as evidenced below:

A. The complainant alleged that the facility was not complying with weekly weights and was also unable to comply with daily weights.

On 06/30/2022 at 1:37 PM, review of Resident

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#3's hospital discharge summary dated 04/08/2022 revealed diagnoses that included left lower extremity cellulitis and bilateral leg edema, Congestive Heart Failure (CHF), Type 2 Diabetes Mellitus, Obesity, Cardiomegaly, and Acute Pulmonary Edema. Review of a physician's order dated 01/15/2022 revealed that on 1/17/2022 there was an order to start weekly weights every Monday, due to congestive heart failure (CHF). Review of a 04/11/2022 case manager note revealed resident weights would be done every Wednesday and that a new wheelchair scale had just been ordered.

For the period from 04/18/2022 to 06/29/2022, facility nurses documented that they could not weigh the resident because there was no available working scale.

Interview with the director of nursing (DON) on 6/30/2022 at 2:38 PM revealed that weights were to be done every Wednesday and one time a month. She stated that no weights had been previously taken for residents in wheelchairs, and that a wheelchair scale had just been ordered. The DON said that a new regular weight scale had been received at the ALR and required assembly.

It should be noted that Resident #11 was also to be weighed weekly, however there was no evidence the resident was being weighed in accordance with the orders.

At the time of the investigation, the ALR failed to ensure weight monitoring as prescribed and in accordance with each resident's needs.

B. The complainant alleged that Resident #9 missed Diabetes Mellitus (DMII) medications for

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several days/weeks because refill requests were sent to the wrong doctor.

On 06/30/2022 beginning at 1:17 PM, review of Resident #9's Service Plan [dated 06/23/2022] showed the resident had diagnoses that included Hypertension, Diabetes Mellitus and Alzheimer's Disease. At 1:22 PM, review of the resident's orders showed Resident #9 was prescribed several medications for diabetes including Metformin 850 mg, Ribelsus 14 mg, and Jardiance 10 mg. Further review of the orders showed that the resident's blood glucose was to be checked twice a day.

At 1:33 PM, review of Resident #9's April 2022 and May 2022 MARs showed the following:

1. The resident did not receive Metformin on 04/16/2022, 05/28/2022, and 05/29/2022.

2. The resident did not receive Rybelsus on 05/01/2022 through 05/05/2022, or on 05/10/2022 and 05/30/2022.

3. The resident did not receive Jardiance on 05/01/2022 through 05/11/2022, or on 05/30/2022.

4. Resident #9's blood glucose was not checked from 05/01/2022 through 05/18/2022, and only checked once on 05/19/2022 and 05/30/2022.

On 07/01/2022 beginning at 12:24 PM, the DON said during an interview that nursing staff should document all medications administered on the MARs. When the surveyor showed the DON the missing documentation on the April 2022 and May 2022 MARs, the DON responded by saying "you're right, the documentation isn't there." The

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R 292	Continued From page 15 DON did not offer any reason as to why nurses failed to document administering the medications and checking the blood glucose, adding that she would re-educate the nursing staff on proper documentation. At the time of the investigation, without verifiable documentation, there was no evidence that Resident #9's treatment orders were followed. C. The complainant alleged that the facility was not complying with Resident #7's order for supplemental oxygen. On 06/30/2022 beginning at 9:07 AM, review of Resident #7's medical record showed the resident's diagnoses included: acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, unspecified, cerebrovascular disease, and sleep apnea. Review of Resident #7's April 2022 and May 2022 MARs showed Resident #7 was not administered the supplemental oxygen continuously every shift as ordered on 04/23/2022, 04/24/2022, 04/28/2002, 05/21/2022, and 05/22/2022. At the time of the investigation, ALR nurses failed to ensure Resident #7's right to receive supplemental oxygen continuously, in accordance with the physician's orders.	R 292		
R 421	Sec. 602a Resident Agreements (a) A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following:	R 421	421 8-31-22 Resident 18 and 19 resident agreement signed by community representative.	

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R 421	Continued From page 16 Based on interview and record review the Assisted Living Residents (ALR) fail to ensure Resident Agreements were signed by a representative of the community, for two of two newly admitted residents (Residents #18 and 19). Findings included; On 06/30/2022 10:15 AM, the Assisted Living Administrator (ALA) Informed the survey team that three new residents were expected to be admitted on that day. Two residents (Residents #18 and 19) were admitted. On 07/01/2022, review of the two Resident Agreements showed that neither document had a signature of a representative of the community. On 07/01/2022 at approximately 3:00 PM, when the Director of Marketing was shown the Resident Agreements, she acknowledged the missing signatures. At the time of the investigation, the ALR failed to ensure that each Resident Agreement was signed by a representative of the community.	R 421	**Resident Agreements (421)** **1. Resident Admission records were reviewed to ensure that the documents had been signed. Records were corrected as needed.** **2. A checklist has been developed to ensure all documents comply.** **3. An audit of newly admitted residents will be performed to ensure compliance. The results of the audit will be presented in the QAPI Committee Meeting** **(See "Clinical Move-IN Checklist)**	
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on Interview and record review, the Assisted Living Residence (ALR) failed to ensure that each resident had a pre-admission Individual Service Plan (ISP) completed, for one of two newly admitted residents (Residents #19). Findings included: On 07/01/2022 at 3:00 PM the director of nursing	R 471		

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R 471	Continued From page 17 (DON) said that an ISP had been developed for Resident #19, who was admitted the previous day (06/30/2022). At 6:30 PM, review of Residents #19's medical record showed no evidence that a pre-admission ISP was completed. No ISP document was made available for review before the investigation ended. At the time of the investigation, the ALR failed to ensure that an ISP was developed for each resident prior to admission.	R 471	**Pre-Admission Individualized Service Plans (471)** 1. **The process for admissions were reviewed with Nursing Administration. Resident ISP have been reviewed/corrected and Updated.** 2. **Pre-admission checklist will be developed /implemented to ensure all preadmission data complies.** 3. **A review of resident documents admitted to the facility will be reviewed to ensure compliance. The results of the report will be submitted to the QAPI committee**	
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on interview and record review, it was determined that the Assisted Living Residence (ALR) failed to update the Individualized Service Plan (ISP) after a significant change in a resident's condition, for one of 17 residents in the core sample. (Resident #13) Findings included: The complainant alleged that Resident #13 sustained a second degree burn and was not receiving treatment. During an interview with the ALR's Nurse	R 483		

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R 483	Continued From page 18 Practitioner (NP) on 06/29/2022 beginning at 10:14 AM, she indicated that on 05/25/2022, Resident #13 informed her that she spilled coffee on her leg two days prior and had sustained a burn. When the NP assessed the resident's thigh, she determined that the resident had sustained a second degree burn to her left upper thigh. The NP gave an order for the nurses to cleanse the wound with Normal Saline, pat dry, and apply Silvadene twice a day. Review of the residents ISP dated 06/23/2022, failed to show evidence that the ISP had been updated to reflect the resident's wound, and prescribed wound treatment to include monitoring for signs and symptoms of infection. Review of the ALR's policy and procedures failed to show evidence of a policy to address the updating of ISP's to reflect changes in a resident's condition. During an interview with the Director of Nursing (DON) on 07/01/2022, she was asked about the resident's ISP update. The DON acknowledged that Resident #13's ISP had not been updated to reflect the wound.	R 483	**Individualized Service Plans (483)** **1. Resident # 13 burn has healed. Resident records were reviewed to assess for any need for updates due to a change in the residents' condition and corrected** **2. Resident ISPs were reviewed for timeliness and content and the need for updating. A calendar was created to ensure resident review dates are not overlooked. Progress notes will also be reviewed for needed updates. Implementation of a 24-hour report. (See Attachment)** **3. ISP report will be submitted to the QAPI committee meetings to ensure compliance.**	
R 583	Sec. 701d1 Staffing Standards. (1) Employ staff and develop a staffing plan in accordance with this act and based upon the following criteria to assure the safety and proper care of residents in the ALR: Based on observation, interview, and record review, the Assisted Living Residence (ALR) failed to have adequate staff and develop a staffing plan to ensure the health and safety of the residents, for 17 of 17 residents in the core	R 583		

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R 583	Continued From page 19 sample. Findings included: A. The ALR failed to have adequate nursing staff, as evidenced below: On 06/29/2022 at 9:53 AM, interview with the acting Assistant Living Administrator (ALA) revealed that the facility's current in-house census was 93 residents. There were also seven residents not in the facility who were either on a leave of absence or in the hospital. The ALA stated that there were 153 apartments in the facility, all of which were located on the second, third, fourth and fifth floors. On 6/29/2022 at 11:40 AM, interview with the Director of Nursing (DON), revealed that there were 16 aides, and staff vacancies for both certified nursing assistant and licensed practical nurses (LPN's) scheduled. She stated that normal staffing pattern was two Licensed Practical Nurses (LPN's) and seven certified nursing assistants (CNAs) during the day and evening shifts, and one LPN and two CNAs during the overnight shift. During the day and evening shifts, one nurse would cover two floors. The overnight shift was covered by one nurse and two CNAs. On 06/29/2022 at 3:53 PM, interview with the DON revealed the ALR was aggressively seeking to hire nurses. She said the ALA was experiencing extreme difficulty recruiting nurses. The DON stated that the ALR relied on staffing agencies to complement the facility staffing. On 06/30/2022 at 9:03 AM, the Acting ALA revealed the facility was expected to admit four new residents, two of whom were admitted on	R 583	**1. The facility is presently staffing to meet the needs of 100 residents 3 Licensed Nurses, 7 CNAs for the Day Shift and 3 Licensed for the Evening Shift 5 CNAs for the Evening 2 Licensed Nurse for the Night Shift and 4 CNAs. The facility has also hired an additional RN as an ADON, and will utilize Supplemental staffing agency. The Supplemental Agency staff will receive in-service/training upon starting to work on the Mandatory topics:** ▪ **Abuse, Neglect and Exploitation** ▪ **Resident Rights** ▪ **HIPAA** ▪ **Emergency Preparedness** ▪ **Dementia** ▪ **Infection Control** ▪ **Electronic HealthCare Records**	

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R 583	Continued From page 20 06/30/2022. At 9:33 AM, the DON informed the survey team that the two LPNs scheduled to work the day shift on 07/01/2022 called out. The DON and Assistant DON therefore were required to provide coverage for the floors in addition to their administrative/supervisory duties. It should be noted that at 11:30 AM, the acting ALA presented a form which showed there were only five CNAs on duty to care for 95 residents on the day shift as opposed to the stated seven CNAs. At 5:08 PM, the DON said that she remained on duty after working the day shift to cover the evening shift. The DON revealed that there was no facility LPN available, and she was not successful in obtaining an agency nurse to help cover the shift. At approximately 6:00 PM, the DON was observed administering the evening medications from two carts stationed on the first-floor hallway, in front of the dining room. The DON said that the medication carts were transferred from their regular stations on the residential floors. She said this was not a usual practice; however, it would maximize the time spent administering medications, and help the residents receive their prescribed medications as soon as possible. The DON later revealed that the staffing agency agreed to send an LPN to work from 8:00 PM that evening who would remain on duty until the next day. It should be noted that at 8:30 PM, the DON was still administering evening medications on the first floor and indicated that she still had 50 more residents to medicate.	R 583	**2. The staffing schedule is reviewed daily to ensure staffing is adequate and will be adjusted as the population increases. The Leadership Team will be in- serviced on Regulation #583** **3. Nursing administration will assess the resident Level of Care monthly to determine staffing needs as it relates to resident needs. Staffing will be adjusted accordingly. Resident LOC reports will be submitted to the monthly QAPI Committee**	

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Beginning at 6:30 PM, the review of the June 2022 LPN schedules showed the following staffing pattern:

Day Shift: 2 LPNs on 20 days and 3 LPNs on 10 days; and (2) Evening Shift:1 LPN on 8 evenings, 2 LPN's on 19 evenings, 3 LPN's on 3 evening. The schedule for the June 2022 overnight shift was requested at 10:13 AM but was not provided. Additionally, the staffing pattern was not available for May or July 2022.

B. The ALR failed to show that they consistently met the facility's stated staffing pattern, as evidenced below:

On 07/01/2022 at 10:13 AM, the Acting ALA, was requested to provide the staffing pattern for May, June, and July 2022. The Acting ALA stated that she would follow-up to inquire about the information requested by the team.

At 7:18 PM, review of the June 2022 CNA schedules showed the following staffing pattern:

Day Shift: 5 CNAs on 7 days; 7 CNAs on 6 days; 3 CNAs on 2 days; 4 CNAs on 5 days; 6 CNAs on 10 days.

Evening Shift: 1 CNA on 6 days; 2 CNAs on 4 days; 3 CNAs on 12 days; 4 CNAs on 3 days; 5 CNAs on 4 days. There was no staff scheduled on 06/11/2022.

Nights:
Overnight Shift: 1 CNA on 5 nights; 2 CNAs on 9 nights; 3 CNAs 10 nights; 4 CNAs on 5 nights. There was no staff scheduled on 06/11/2022.

At 7:25 PM, review of the May 2022 CNA

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R 583	Continued From page 22 overnight schedules showed the following staffing pattern: 1 CNA on 6 nights; 2 CNAs on 7 nights; 3 CNAs on 12 nights; 4 CNAs on 4 nights. There was no staff scheduled on 05/14/2022 and 05/20/2022. On 07/01/2022 at 11:30 AM, the surveyor requested from the acting ALA a per-shift accounting of actual staff hours worked during the previous month. The acting ALA said she was unable to "get into the system" to obtain the information. Without the actual staff hours worked, the survey team could not verify staff coverage. C. The schedule for the July 2022 was not made available for review. D. On 07/05/2022 at 9:37 AM, review of the policy and procedures revealed the facility did not have a policy to address the ALR's staffing requirements related to the increase in the resident census. At the time of the investigation, the ALR failed to establish a written staffing plan necessary to meet the health and safety needs of the residents of the facility.	R 583		
R 710	Sec. 802 4 Medical, Rehabilitation, Psychosocial Assess. (4) Confirmation that the applicant is free from communicable TB and from other active, infectious, and reportable communicable diseases. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure	R 710	**Medical, Psychosocial Assess (710)** **1. Nursing Administration reviewed the admission protocol regarding Infectious Disease. The Resident records will be reviewed prior to admission to ensure all necessary documentation is complete inclusive of ISP, TB /Chest X-ray forms. A checklist will be implemented to ensure record compliance.** **2. Nursing Administration and Admissions will review/audit pre-admission procedures/ documents to ensure compliance, and ensure the resident is free of infection prior to admission** **3. Results of the audit will be reported during the monthly QAPI Committee Meeting.**	

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a required test was performed prior to admission to rule out communicable disease (tuberculosis), for one of 17 residents in the core sample (Resident #12) and one of two newly admitted residents (Resident #18).

Findings included:

1. The complainant alleged that Resident's #12 was admitted to the ALR with a positive QuantiFERON-TB (TB Test) from March 2022, but a negative chest X-ray from 2018. The complainant said the resident needed to be evaluated at a tuberculosis (TB) clinic, due to having apparently contracted TB seven years before his admission to the ALR.

On 6/27/2022, at 9:22 AM, during an interview with the Nurse Practitioner (NP), she said Resident #12 informed her that when the TB was diagnosed seven years earlier, he was given antibiotics for 10 days in an emergency room (ER). The resident however, said he did not receive follow-up after taking the antibiotics and his last primary care physician told him he would always have a positive TB test. The NP said she placed a referral in the resident's record for an assessment to rule out latent TB.

On 7/1/2022 at 3:37 PM, review of Resident #12's admission medical assessment (dated 03/29/2022) revealed a "positive QuantiFERON (TB test) test with a negative chest X-ray." The assessment however, failed to include the date that the X-ray was performed. The form noted "Based on my findings and on my knowledge of this patient, I find the patient is not exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact."

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On 7/01/2022 at 4:03 PM, review of Resident #12's record showed a medical visit summary report dated 3/24/2022. Attached to the visit summary report was an X-ray report dated 3/28/2018, which showed "normal chest."

On 07/01/2022 at 4:23 PM, review of Resident #12's Pre-Admission Clinical Evaluation (dated 04/29/2022), which was completed by the registered nurse (RN) showed no mention of the resident's "positive QuantiFERON test with a negative chest X-ray" identified in the admission medical assessment. Additionally, prior to admission, the resident had not been reassessed to verify that the resident did not have latent TB.

Interview with Resident #12 on 7/01/2022 at 6:37 PM, revealed that he was admitted to the facility from the community on 05/02/2022. When interviewed on 06/30/2022, the DON revealed that when the nurse practitioner (NP) discovered the resident's previous Tuberculin status on 05/18/2022, it was brought to her and the Assisted Living Administrator's (ALA's) attention.

On 07/01/2022, at 4:28 PM, review of a medical note dated 05/18/2022 revealed the DON and the ALA were notified when it was learned that Resident #12 did not have a follow-up chest X-ray before admission to determine his current tuberculin status. The resident was then referred for a stat chest X-ray to rule out latent tuberculosis. Mobile imaging came to the ALA on 05/21/22 to perform then X-ray and the results were reported negative. The resident was then given a referral for an infectious disease assessment. At the time of the investigation, the outcome of the referral assessment had not been determined.

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R 710	Continued From page 25 On 07/01/2022 at 4:38 PM, review of the agency policy showed that the physician will need to document that each resident is free from infectious disease. At the time of the investigation, the ALA failed to confirm that Resident #12 was free from tuberculosis in a communicable form at the time of admission. 2. On 07/01/2022 at 6:00 PM, review of the Intermediate Care Facilities Division Admission/Annual Medical Certification form for a newly admitted resident (Resident #18) showed no evidence that the resident's TB status was documented. When interviewed, the DON acknowledged the omission of the information and gave no additional information, as she was providing direct care to a resident at the time. At the time of the investigation, there was no evidence that the ALR ensured residents were free from active TB prior to admission.	R 710		

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R 000	Initial Comments	R 000	Please start typing your responses here:	

0000 Initial Comments
On 06/26/2022, the District of Columbia Health Regulation and Licensing administration (DC Health's) Intermediate Care Facilities Division received an anonymous complaint regarding concerns for the health and safety of the residents residing at Livingston Place Assisted Living Residences (ALR).

Due to the nature of the allegations, the State Survey Agency (SSA) initiated an on-site investigation on 06/29/2022 through 07/12/2022 to determine compliance with the Assisted Living regulations and the Assisted Living Law "DC Code § 44-101.01". The ALR is licensed for a total capacity of one hundred and fifty-three (153) residents. The census as of 06/30/2022 was 93 residents, and seven (7) residents who were away from the facility.

In addition, the Acting Assisted Living Administrator informed the survey team that four new residents were expected to be admitted during the month of July 2022. A total of 19 residents were sampled for the investigation [17 current resident records and two newly admitted residents].

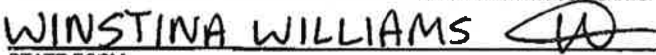
The complainant alleged the following:

1. "Resident #2 continued to receive her old dose of Trulicity [Diabetic medication] after it was increased to 1.5 mg every week on 03/23/2022. The ALR did not change the order until 04/14/2022."

Conclusion: Substantiated.

2. "Resident #3 never started on Rosuvastatin

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


WINSTINA WILLIAMS — EXECUTIVE DIRECTOR — 9/16/22

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[hypercholesterolemia] that was ordered March 2022 and never received her Levaquin and Linezolid on 04/11/2022 as ordered."

Conclusion: Substantiated

3. "Resident #4 received ferrous sulphate [Iron supplement] tablets five times daily instead of the three times a day and then twice a day after one month as ordered."

Conclusion: Substantiated

4. "Resident #5 did not receive her prescribed medication of Levothyroxine [hypothyroidism] from 05/03/2022 through 05/10/2022, 05/12/2022 and 05/13/2022."

Conclusion: Substantiated

5. "Nurses did not know what medications they were administering to patients when asked by the patient or patient family."

Conclusion: Not substantiated

6. "Resident #6's family reported that the resident did not receive her medications on a Monday and when they notified the nurse, she said that they (the nurse) would be on a different floor for evening medication pass."

Conclusion: Substantiated

7. "Resident #7 did not get her medications for one to three days after her return from the hospital."

Conclusion: Substantiated

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R 000	Continued From page 2 8. "Nurses were not assessing the resident's vital signs, weights, B/P and glucose monitoring as ordered." Conclusion: Substantiated 9. "Resident #9 missed several days/weeks of her Diabetic medications since refills were sent to the former Primary Care Physician, who stated the resident was no longer under their care." Conclusion: Partially substantiated 10. "Resident #10 had orders for Seroquel to be administered on Saturdays, but the nurses never administered the medication." Conclusion: Not substantiated 11. "Resident #1 had trouble receiving some of his medications as one nurse is covering two floors." Conclusion: Substantiated 12. "Nurses were not administering medications in accordance with physician's orders." Conclusion: Substantiated 13. "There were delays in the residents receiving their medications." Conclusion: Substantiated 14. "Residents were being admitted without determining their health status [tuberculosis (TB)]." Conclusion: Substantiated	R 000		

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15. "There was a delay in a resident receiving the proper care because the nurses did not know the signs and symptoms of a stroke."

Conclusion: Substantiated

16. "Resident #11 had an order for Azithromycin [antibiotic] (Z-Pack) on 5/11/2022 and never received the medication."

Conclusion: Not Substantiated

17. Direct Care Nurses were informed about Resident #13's burn wound and did not report it to the Nurse Practitioner or Registered Nurse, resulting in a delay in the proper treatment of the wound. Resident #13 did not receive prescribed Bactrim.

Conclusion: Partially Substantiated

18. The ALR nursing staff performed a COVID PCR swab on Resident #10, placed the swab in the Lab Corp box and failed to call Lab Corp for pick-up.

Conclusion: Substantiated

The investigative findings were based on observations, interviews with the complainant, direct care staff, management staff, residents, family member and review of administrative and clinical records. The investigation determined that the ALR failed to be in compliance Assisted Living Regulations and the Assisted Living Law "DC Code § 44-101.01". The deficient practices are addressed throughout this report.

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R 074	Continued From page 4	R 074	**Admissions (074)**
R 074	10108.2 Admissions 10108.2 Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all areas addressed, for two of two newly admitted residents in the investigation (Residents #18 and 19). Findings included: a. On 07/01/2022 at 10:30 AM, review of Resident #18's medical certification form, dated 06/03/2022, showed that the physician did not address the resident's tuberculosis status, did not list the resident's medications, and did not indicate if the resident had or was in need of a Papanicolaou (PAP) test. b. On 07/01/2022 at 11:12 AM, review of Resident #19's medical certification form, failed to show evidence that the physician documented the date, the name of the facility or indicate if the resident had or needed a PAP test. On 07/01/2022 beginning at 4:30 PM, the ALR's Director of Nursing acknowledged the findings and stated that the ALR would explore strategies to get the physicians to complete all sections of the form. At the time of the investigation, the ALR failed to ensure that all sections of the form were completed by the physician for each resident.	R 074	**1. Resident 18 & 19 items missed on the medical certification have been addressed with MD. #18 had colposcopy completed 7/22/2022. PAP test awaiting MD response for TB test or CXR to confirm free of communicable disease be completed as of 9-1-2022.** **2. 9-1-2022 Clinical Move-IN checklist tool will be utilized to ensure compliance. The Executive Director/designee will educate the Marketer/Admission and Nursing Leadership on the need for all sections of the Admission/Annual certificate is completed in entirety by 9-15-2022.** **3. The Executive Director/designee will ensure is completed. Clinical checklist and Medical Certificate will be audited, and the results will be reported in the monthly QAPI meeting**
R 108	10110.2a Required Policies And Procedures	R 108	

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R 108	Continued From page 5 10110.2a (a)Medication management, administration of medication, medication administration errors, and medication storage; Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed to have required policies and procedures that clearly defined the medication administration process, how staff should document the administration of medications in each resident's record, and how to address medication errors, including missed medications, for five of 17 residents in the core sample (Residents #4, 5, 6, 7, and 9). Findings included: 1. The complainant alleged that Resident #7 did not receive medications, as ordered. On 06/30/2022 at 9:07 AM, review of Resident #7's medical record showed the resident had diagnoses that included acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, unspecified protein-calorie malnutrition, Type II Diabetes Mellitus w/o complications, chronic obstructive pulmonary disease, unspecified, human immunodeficiency virus (HIV) disease, cerebrovascular disease, major depressive disorder, suicidal ideation's, sleep apnea, arteriosclerotic heart disease of native coronary artery without angina pectoris, hypothyroidism, bipolar, schizoaffective disorder, syncope and collapse, orthostatic hypotension... On 06/30/2022 beginning at 9:10 AM, review of Resident #7's April 2022, May 2022, and June 2022 Medication Administration Records (MARs) showed the following:	R 108	**Policies and Procedures (R108)** **1. In-service /Training was conducted on 8/18 and 8/24 with the Licensed Nursing staff regarding Medication Administration.** **2. (a)A review was conducted with the Nursing Administration 8/29/2022 on the Company's policies on Medication Administration, Receiving Medication Verification, Medication Ordering, and Controlled Medication Monitoring. (b)Nursing Administration will continue Medication observations as well as Medication Admin. Audits to ensure compliance. An onboarding checklist will be utilized for the new hires beginning 9/1/2022. The skills checklist will be placed in the employee's file.** **3. The Leadership team will be updated on the use of the Policy and Procedure Manual's location (electronic /hard copy) who will in turn educate line staff on the same.**	

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- Ferrous Sulfate (iron supplement) 325 mg was to be taken one tablet by mouth three times a day for anemia. The MAR showed that the medication was not administered on 04/05/2022, 05/10/2022, 05/11/2022, and 06/04/2022.

- Resident #7 was not administered the supplemental oxygen continuously every shift as ordered on 04/23/2022, 04/24/2022, 04/28/2002, 05/21/2022, and 05/22/2022.

- Breo Ellipata (Asthma)100-25 mcg, inhale one puff daily. The May 2022 MAR showed that the medication was not administered on 05/05/2022, 05/10/2022, and 05/11/2022.

- Fluticasone (Rhinitis) 50 mcg spray, inhale one spray in each nostril daily. The MARs showed that the medication was not administered on 04/05/2022, 04/11/2022, and 05/10/2022.

- Metformin (Diabetes Mellitus)1000 mg, one tablet twice a day. The MAR showed that the medication was not administered on 04/05/2022.

- Resident #7's April 2022 and May 2022 MARs also showed no evidence that the resident received the following medications as ordered on 04/05/2022 and 05/10/2022: Etravirine 200 mg, (human immunodeficiency virus (HIV), Levothyroxine 137 mg (hypothyroidism), Omeprazole Capsule 20 mg (gastroesophageal reflux disease) (GERD), Prezista 600 mg (HIV), Ritonavir 100 mg, and SMZ/TMP DS TAB 800-600 (HIV).

On 07/01/2022 beginning at 12:24 PM, the Director of Nursing (DON) said during an interview that nurses were to document all medications administered on the MARs. When

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the surveyor showed the DON the missing documentation on Resident #7's MARs, the DON responded by saying "you're right, the documentation isn't there." The DON did not offer any reasons as to why nurses failed to document the administration of the medications, adding that she would re-educate the nursing staff on medication administration documentation.

2. The complainant alleged that the facility was not complying with Resident #7's order for continuous supplemental oxygen.

On 06/30/2022 beginning at 9:07 AM, review of Resident #7's medical record showed the resident's diagnoses included: acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, unspecified, cerebrovascular disease, and sleep apnea. Review of Resident #7's April 2022 and May 2022 MARs showed Resident #7 was not administered the supplemental oxygen continuously every shift as ordered on 04/23/2022, 04/24/2022, 04/28/2002, 05/21/2022, and 05/22/2022.

At the time of the investigation, ALR nurses failed to ensure Resident #7's right to receive supplemental oxygen continuously, in accordance with the physician's orders.

3. The complainant alleged that Resident #9 missed Diabetes Mellitus (DMII) medications for several days/weeks because refill requests were sent to the wrong doctor.

On 06/30/2022 beginning at 1:17 PM, review of Resident #9's Service Plan (dated 06/23/2022) showed the resident had diagnoses that included Hypertension, Diabetes Mellitus and Alzheimer's

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Disease. At 1:22 PM, review of the resident's orders showed Resident #9 was prescribed several medications for diabetes including Metformin 850 mg, Rybelsus 14 mg, and Jardiance 10 mg. Further review of the orders showed that the resident's blood glucose was to be checked twice a day.

At 1:33 PM, review of Resident #9's April 2022 and May 2022 MARs showed the following:

a. The resident did not receive Metformin on 04/16/2022, 05/28/2022, and 05/29/2022.

b. The resident did not receive Rybelsus on 05/01/2022 through 05/05/2022, or on 05/10/2022 and 05/30/2022.

c. The resident did not receive Jardiance on 05/01/2022 through 05/11/2022, or on 05/30/2022.

d. Resident #9's blood glucose was not checked from 05/01/2022 through 05/18/2022, and only checked once on 05/19/2022 and 05/30/2022.

On 07/01/2022 beginning at 12:24 PM, the DON said during an interview that nursing staff should document all medications administered on the MARs. When the surveyor showed the DON the missing documentation on the April 2022 and May 2022 MARs, the DON responded by saying "you're right, the documentation isn't there." The DON did not offer any reason as to why nurses failed to document administering the medications and checking the blood glucose, adding that she would re-educate the nursing staff on proper documentation.

At the time of the investigation, without verifiable

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documentation, there was no evidence that Resident #9 received all medications as ordered and the resident's treatment orders were followed.

4. The complainant alleged that Resident #4 was administered five tablets of Ferrous Sulfate daily instead of three tablets daily for the first 30 days and then two tablets a day thereafter.

Resident #4's Individual Service Plan (ISP), dated 06/23/2022, provided a long list of diagnoses, including iron deficiency anemia. The ISP also said "<Resident #4> requires daily supervision of medication. Initiated 01/09/2022." [Note: The plan did not further elaborate re: "daily supervision."

On 06/30/2022 beginning at 11:44 AM, Resident #4's Medication Administration Record (MAR) for 04/2022 showed two concurrent orders for Ferrous Sulfate. One order read: "Ferrous Sulfate Tab 325 milligrams (mg), 1 tablet by mouth three times a day for 30 days. Iron deficiency anemia." The other order read: ""Ferrous Sulfate Tab 325 mg, 1 tablet by mouth twice a day" (without indicating a start date). The 04/2022 MAR showed the designated administration times for the two orders were at 8:00 AM, 2:00 PM, and 8:00 PM, and 8:00 AM and 8:00 PM, respectively. According to the MAR, the first dose was administered on 04/23/2022 at 8:00 PM. Nurses documented administering both the TID and BID Ferrous Sulfate tablets each day through the end of April.

Resident #4's 05/2022 MAR also listed both orders for Ferrous Sulfate (see above) for the period 05/01/2022 through 05/20/2022. Nurses continued documenting the administration of Ferrous Sulfate tablets on both lines (TID and

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BID orders). Beginning on 05/21/2022, however, nurses documented administering one Ferrous Sulfate Tab 325 mg twice a day (the TID order had stopped).

Resident #4's nurse progress notes reflected contradictory documentation made by medication nurses. For example, a Licensed Practical Nurse (LPN #6) wrote on 04/24/2022 at 9:10 PM "Ferrous Sulfate Tab 325 mg, 1 tablet by mouth three times a day for 30 days. Duplicate order." Two days later (04/26/2022 8:08 PM), LPN #6 wrote "Ferrous Sulfate Tab 325 mg, 1 tablet by mouth twice a day. Duplicate order." A progress note made by LPN #7 on 05/07/2022 at 7:01 PM said: "Ferrous Sulfate Tab 325 mg, 1 tablet by mouth three times a day for 30 days. Duplicate order." On the next day, 05/08/2022 at 8:44 PM, LPN #6 wrote: "Ferrous Sulfate Tab 325 mg, 1 tablet by mouth twice a day. Order has been changed to three times daily." On 05/12/2022 at 9:51 PM, 05/13/2022 at 10:00 PM, and on 05/16/2022 at 9:30 PM, LPN #6 again wrote: "Ferrous Sulfate Tab 325 mg, 1 tablet by mouth twice a day. Order has been changed to three times daily." The first progress note indicating contact with either the pharmacist or a supervisory Registered Nurse was entered by LPN #7 on 05/21/2022 at 10:51 AM when LPN #7 wrote "Ferrous Sulfate Tab 325 mg, 1 tablet by mouth twice a day. Call made to pharmacy." That was near the conclusion of the initial 30-day period when the MAR showed nurses documenting the administration of both orders concurrently.

On 06/30/2022 beginning at 2:29 PM, the Director of Nursing (DON) reviewed Resident #4's 04/2022 and 05/2022 MARs and the physician's order sheets (POS) printed on 06/29/2022

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(current). The DON said she was unable to say how many Ferrous Sulfate tablets were administered to Resident #4 each day prior to 05/21/2022. When asked if nurses could make changes to a resident's MAR, the DON stated that nurses were permitted to make changes to an MAR. They must, however, know the physician's "NPI number" to enter the electronic system. She further stated that "nurses need to be educated about NPI numbers." It remained unclear who was responsible for maintaining the residents' MARs. She acknowledged that the documentation suggested that Resident #4 received five Ferrous Sulfate tablets a day.

On 07/1/2022 at 2:14 PM, the facility sent by email Resident #4's physician's order sheets (POS) for the period 04/1/2022 through 05/31/2022. The POS were printed from the internal system used by the ALR. The 04/2022 POS showed the two iron supplement orders running concurrently, with the same start date of 04/21/2022 on each. The facility did not, however, have available for review the original order(s) written by the prescribing physician. Without having the original orders available, the survey team could not determine whether the physician wrote unclear orders initially or if there was a transcription error made after the initial orders were sent by the physician.

On 07/06/2022 beginning at 2:25 PM, LPN #6 was interviewed by telephone. When asked if she recalled Resident #4 having two concurrent orders for Ferrous Sulfate, one order saying to administer one tablet three times a day and the other order saying twice a day, she replied she did not remember. When the surveyor mentioned that she had entered progress notes on 4/24/2022, 4/26/2022, 05/07/2022, 05/08/2022,

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05/12/2022, 05/13/2022 and 05/16/2022, she explained that she was at home and could not access the progress notes. LPN #6 said she did not recall how many tablets of Ferrous Sulfate she administered to Resident #4. Continued conversation revealed that approximately 90% of the time, the doctor or nurse practitioner sent orders for new medications directly to the pharmacy electronically. LPN #6 also stated that facility staff would not telephone the prescribing physician to seek clarification of an order; "the pharmacist would call the doctor to confirm this order."

On 07/06/2022 at 2:56 PM, LPN #2 was contacted by telephone. Resident #4's MAR and nurse progress notes showed that she had administered the resident's Ferrous Sulfate supplement on numerous occasions during the initial 30 days prescribed. However, when she was asked if she recalled Resident #4 having two concurrent orders for Ferrous Sulfate, one that said to administer it three times a day and the other order that said to administer it twice a day, she said she was not at her computer at the moment and did not recall.

On 07/12/2022, the prescribing physician forwarded the original order for Resident #4's Ferrous Sulfate (iron supplement) (dated 04/21/2022), which read as follows: "Ferrous Sulfate 325 milligram (65 mg iron) tablet. Take one tablet by mouth three times daily (TID) times 30 days then one tablet by mouth twice a day (BID)." The evidence showed that the physician's initial order was mistakenly transcribed as two concurrent orders on the MARs and the ALR's nursing team failed to take corrective action.

5. While reviewing Resident #4's MARs and POS,

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two concurrent orders for Vitamin D 2 supplements were identified. This was similar to the concurrent Ferrous Sulfate orders discussed above. One order said to administer one 50,000-unit capsule weekly for twelve weeks, and the other order said to administer one 50,000 unit capsule each month. According to Resident #4's 04/2022 MAR, the resident was administered a 50,000-unit capsule on 04/28/2022. The 05/2022 MAR showed the resident was administered a 50,000-unit capsule weekly (on 05/05/2022, 05/12/2022, 05/19/2022, and 05/26/2022). The MAR also showed that on 05/21/2022, LPN #7 wrote a progress note. The corresponding progress note (entered at 8:51 PM) said: "Vitamin D 2 50,000-unit capsule take one capsule by mouth once a month. Call made to pharmacy." The nurse did not, however, indicate whether she reached the pharmacist or if new information was obtained. Resident #4's 06/2022 MARs showed that she was administered 50,000 units of Vitamin D2 weekly (on 06/02/2022, 06/09/2022, 06/16/2022, and 06/23/2022) and she also received a once-monthly 50,000-unit capsule administered on 06/20/2022.

On 07/12/2022, the prescribing physician forwarded the original order for Resident #4's Vitamin D2 supplement (dated 04/21/2022), which read as follows: Vitamin D2 1,250 micrograms (50,000 unit) capsule. Take one capsule by mouth once a week times 12 weeks then one capsule by mouth once a month. The evidence showed that the physician's initial order was mistakenly transcribed as two concurrent orders (both starting on 04/21/2022) on the MARs and the ALR's nursing team failed to take corrective action.

6. The complainant alleged that Resident #5 was

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R 108	Continued From page 14 not administered Levothyroxine on 05/03/2022 through 05/10/2022, then again on 05/12/2022 and 05/13/2022, as ordered. [Cross-reference R373.] On 06/29/2022 beginning at 11:36 AM, Resident #5's 05/2022 Medication Administration Record (MAR) showed the following order: "Levothyroxine Tab 137 microgram, 1 tablet by mouth every morning. Hypothyroidism." The designated administration time was 6:00 AM. The MAR showed no evidence that nurses administered the Levothyroxine on the mornings of 05/03/2022 through 05/10/2022, 05/12/2022 through 05/15/2022, confirming the allegation. The MAR showed Resident #5 did not receive the Levothyroxine on 13 of the first 19 days in 05/2022. Resident #5's 04/2022 showed no evidence that nurses administered the Levothyroxine on 17 out of 30 mornings in 04/2022. Resident #5's nurse progress notes did not include any progress notes that explained why the resident did not receive the Levothyroxine 137 micrograms every morning, as prescribed. 7. The complainant also alleged that (a) Resident #5 did not receive insulin at 2:00 PM and, (b) the resident missed entire medication administrations. Both allegations were substantiated; insulin was not administered at 2:00 PM on 04/13/2022 and an entire medication administration was missed on 04/16/2022, for reasons not documented in the resident's record (See R373). 8. (Cross-reference to R373.9) Resident #5 did not receive the full 10- day regimen of Ciprofloxacin (Cipro) HCL 500 mg twice daily,	R 108		

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beginning 04/07/2022. She was not administered Cipro on the last two days of the 10-day cycle.

9. [Cross-reference R373] Resident #6 MARs for April 2022 showed that the resident did not receive medications on the mornings of 04/01/2022, 04/02/2022, 04/04/2022 or the evening of 04/01/2022 through 04/04/2022, with no explanation documented by nurses. In addition, Resident #6 did not receive Metformin at 8 AM, on 05/06/2022.

10. [Cross-reference R373] A review of Resident #6's progress notes showed that the resident was to begin a 10-day treatment with Bactrim antibiotic twice daily. Nurses documented administration on 04/28/2022 and 04/29/2022. There was no evidence that Resident #6 received the Bactrim on the remaining eight days (16 doses). Bactrim was not reflected on the resident's MARs.

It should be noted that the investigation identified numerous other incomplete and/or contradictory documentation entries in resident records. (See R373)

Review of the facility's policies and procedures manual failed to show evidence of written policies and procedures that would provide guidance regarding: (1) creating and maintaining a resident's monthly MAR, (2) facility nurses clarifying medication orders, or (3) nurses documenting the administration of each medication on an MAR.

R 109	10110.2b Required Policies And Procedures	R 109		

10110.2(b) Developing, reviewing, and revising a

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resident's ISP, including policies on addressing a resident's (or surrogate's) disagreement with an ISP in part or whole and using a shared responsibility agreement (SRA) to resolve remaining discrepancies between the individual resident's right to independence and the ALR's concerns for the safety and wellbeing of the resident and others.

Based on interview and record review, the Assisted Living Residence (ALR) failed to have a policy/procedure regarding the development and revision of a resident's Individualized Service Plan (ISP), for one of 17 residents in the core sample (Resident #13) and one of two newly admitted residents (Resident #18).

Findings included:

1. The ALR failed to implement its policy on developing an ISP prior to admissions, as evidenced:

Resident #18 was admitted to the facility on 06/30/2022. On 07/01/2022 at 9:50 AM, the surveyor requested a copy of Resident #18's ISP from the Director of Nursing (DON). The DON stated that she would provide a copy of the ISP; however, no ISP was provided for review before the end of the investigation.

On 07/01/2022, review of the ALR's policy and procedures manual showed the following:

"E-100 Coordination/Individualization of Services... Following the residency assessment and move-in, an individualized assistance/service plan will be developed prior to move-in."

At the time of the investigation, the ALR failed to develop an ISP for Resident #18 prior to

Policy and Procedure (R109) ISP

1. **A review Residents ISP were conducted and those resident out compliance were corrected by 8/31/2022. A pre-admission checklist will be implemented to ensure pre-admission compliance.**
2. **The Leadership Team will be educated on the Company's Policy and Procedures with emphasis on the Individualized Service Plan (ISP) (electronic and Hardcopy) by 9/15/2022. The Leadership team will Inservice line staff on the same.**
3. **The staff will be audited for compliance and the results of the audit will be presented in the QAPI Committee Meeting.**

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admission.

2. The ALR failed to revise a resident's ISP following a change in health condition, as evidenced below:

[Cross-reference to R 483] On 06/29/2022 at 10:14 AM, the ALR's Nurse Practitioner (NP) noted that on 05/25/2022, Resident #13 informed her that she spilled coffee on her leg and had sustained a burn. Upon assessment, the NP determined that the resident sustained a second degree burn to her left upper thigh. An order was given by the NP for the wound to be cleansed with Normal Saline, pat dry, and apply Silvadene (topical antimicrobial drug) twice a day.

Review of Resident #13's ISP showed that it had been reviewed on 06/23/2022. There was no evidence to show that the ISP had been updated to reflect the residents wound, and wound care interventions to include monitoring for signs and symptoms of infection.

On 07/01/2022, review of the ALR's policy and procedures failed to show evidence of a policy that addresses updating ISPs after a change in a resident's condition.

On 07/01/2022, the Director of Nursing (DON) was asked about Resident #13's ISP update. The DON acknowledged that Resident #13's ISP had not been updated to reflect the resident's change in condition.

At the time of the investigation, the ALR failed to ensure each ISP was revised to reflect changes in the resident's condition.

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R 125	Continued From page 18	R 125		
R 125	10110.2r Required Policies And Procedures 10110.2(r) Determining when an ambulance or emergency medical services are contacted during a health emergency. Based on interview and record review, the Assisted Living Residence (ALR) failed to implement its policies and procedures on determining when to request emergency medical services, for two of 17 residents in the core sample (Residents #8 and 15). Findings included: Policy I-140 ...."Emergency Care" to assure adequate response to resident emergencies. Residents will receive appropriate emergency care and will have an emergency call system in their dwelling unit. Staff will be trained in first aid and cardiopulmonary resuscitation (CPR) for early management of problems. When in doubt, the emergency medical services system will be activated."... When the staff at the Community determines that, in its judgement, an emergency situation exists, staff will call 911." Policy I-155 - "Summoning Help. When it is apparent that a resident is in need of medical help, the staff member will call the ambulance, 911, and notify the on-staff nurse. Stay with the resident until help arrives... Notify the Manager, who will in turn contact the family or responsible person." A. On 06/29/2022 beginning at 12:54 PM, the Nurse Practitioner (NP) said during an interview that she was informed on 06/26/2022 that Resident #8 was taken to the emergency room for a stroke at 7:00 PM on the night before	R 125	**Medical Emergency (R125)** **1. Licensed Nurses were in-serviced/trained on the 8/18 and 8/24. Topics included: Medical Emergency Procedure and Protocol and the need to summon 911.** **2. Additional training will be provided to staff on the Company Policy/Procedure for Emergency Care by 9/25/2022. Additional training will be provided on "Guidelines on when to Notify the Physician" by 9/30/2022.** **3. Emergency /Transfers will be reviewed for compliance in documentation and appropriate procedure. The results of the review will be submitted to the QAPI committee.**	

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(06/25/2022). She further stated she did not know how long the resident was exhibiting signs and symptoms of stroke prior to the call for 911/Emergency Medical Services (EMS). According to the hospital discharge summary, the patient was outside the window for tissue plasminogen activator [tPA].

On 06/29/2022 at 3:00 PM, during an interview, LPN #1 stated that Resident #8 informed her on 06/25/2022 that he felt like he was having a stroke. LPN #1 assessed the resident's vital signs which she stated were within normal limits. Resident #8 then called his family members in North Carolina (early morning) to inform them that he thinks he is having a stroke. The family in North Carolina then called a local family member who eventually came to the facility later that day. The local family member requested that the ALR nurse call 911 due to slurred speech and left side weakness. LPN #1 acknowledged that she did not document the time that EMS arrived nor did she document the time that EMS took the resident to the emergency room.

B. According to the NP, on 06/18/2022, LPN #6 called her three times regarding Resident #15. At 3:57 PM, the nurse informed the NP that the resident was "... a little confused and did not feel good." The nurse was not able to provide more information to the NP. At 6:44 PM, LPN #6 called the NP and informed her of the urine dipstick results and that the resident was trying to eat a sandwich but was not using her hands. At 8:01 PM, the LPN #6 called the NP to inform her that the paramedics were concerned that the resident may be having a stroke. The NP stated that she asked the LPN if the resident was having weakness on her left side, to which the LPN responded, "I think it got worse." The NP further

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R 125	Continued From page 20 stated that she asked the LPN if she performed a neurological assessment, to which LPN #6 admitted that she had not performed a complete assessment.	R 125	**Training (R129)** 1. **Licensed Staff received training on 8/18 and 8/24on Medication Management, MAR documentation, Emergency Procedures and Updating the Service Plan when there is a change in condition.** 2. **The Nursing Leadership Team was provided training on 8/29/2022 on the use of a checklist to be implemented for new hires. Updates for a licensed staff will be ongoing to ensure compliance with: Medication Management, MAR documentation, Medical Emergency Procedure, and ISP updating. An ISP Calendar was created to ensure the timeliness of updating the ISPs.** 3. **An audit of the ISP will be conducted monthly to ensure compliance and the results will be reviewed at the QAPI meeting**	
R 129	10110.4 Required Policies And Procedures 10110.4 An ALR shall train its staff in the proper implementation of its procedures. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure each staff received ongoing training on: I. procedures for medication management, II. maintaining medication administration records, III. identifying, reporting, and recording significant changes in a resident's condition, and IV. implementing emergency procedures, for eight of 17 residents in the core sample (Residents #3, 5, 6, 7, 8, 10, 13, and 15). Findings included: I. The ALR failed to ensure ongoing and effective training on medication administration, as evidenced below: A. Resident #6 was not administered Metformin 1000 milligram twice a day as ordered by the physician, as follows: According to Resident #6's 05/2022 Medication Administration Record (MAR), the resident was not administered Metformin at 8:00 AM on 05/06/2022. In a corresponding nurse progress note, LPN #2 wrote "Hold for finger stick of 98 milligram per deciliter." The resident's physician's order sheet (POS) for 05/2022 said: "Metformin Tab 1000 mg. Take 1 tablet by mouth twice a day." The POS did not say to perform finger	R 129		

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sticks and the MAR did not reflect any finger sticks being documented. Neither the POS nor the MAR said the administration of the Metformin would be contingent upon the results of finger sticks. Resident #6's POS indicated that her diabetes was controlled by the administration of Metformin and eating a "diabetic diet ... no concentrated sweets."

On 06/30/2022 at 3:10 PM, LPN #2 was shown the 05/06/2022 progress note and Resident #6's 05/2022 MAR. She confirmed that she had held the Metformin that morning. When asked about parameters on blood glucose levels, she acknowledged there were no parameters indicated on the orders or MAR. When asked why a reading of 98 led her to hold the medication, she replied the reading indicated that the resident's blood sugar was low at the time.

In an email sent to Resident #6's primary physician on 07/07/2022, the surveyor asked how often should facility staff take a finger stick reading? They also requested the original order for Metformin (ordered 03/16/2020) and asked the physician whether she wanted staff to administer the Metformin twice a day, regardless of blood glucose levels. No additional information about Resident #6's Metformin and finger sticks was received.

At the time of the investigation, the ALR failed to ensure that Resident #6 was administered Metformin twice daily, in accordance with the physician's orders.

B. The investigation findings also showed that Resident #3 did not receive Levaquin and Linezolid as prescribed. Resident #3 did not receive Rosuvastatin for a two-week period in

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R 129	Continued From page 22 March 2022. Resident #5 did not receive Levothyroxine on 17 of 30 mornings in April 2022 and 13 of the first 19 mornings in May 2022. In addition, Resident #5 was not administered insulin on 04/13/2022 at 2:00 PM or receive any evening medications on 04/16/2022. Resident #5 also only received 17 out of 20 doses of Cipro prescribed in April 2022. Resident #10 did not receive Januvia 50 mg for five days as ordered, between 05/26/2022 and 06/01/2022. (See R 292 and R373) On 06/29/2022 at 10:00 AM, the survey team requested documentation of all staff training provided since 04/19/2022. No information was forthcoming. On 06/30/2022 at 11:54 AM, the Director of Nursing (DON) was asked about staff training that had been provided since she was hired full-time in May 2022. The DON said she provided periodic ongoing training. She acknowledged however, that she did not document the date, time, or topics she covered. In addition, she said there was no documentation available regarding training's provided by the previous administration. II. The ALR failed to ensure ongoing and effective training on maintaining medication administration records, as evidenced below: The investigation showed that nursing staff failed to document on an MAR the administration of Bactrim antibiotic to Resident #7 for ten days beginning 04/28/2022, and Resident #13 for ten days beginning on 05/25/2022. Resident #16's May 2022 and June 2022 MARs did not document every administration of Oxycodone (pain medication), as indicated by the resident's narcotic medication count sheet. See (R 108 and R373. I)	R 129		

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On 06/29/2022 at 10:00 AM, the survey team requested documentation of staff training. No documentation of staff training was made available during the investigation.

III. The ALR failed to ensure ongoing and effective training on identifying, reporting, and recording significant changes in a resident's condition, as evidenced below:

The investigation showed that Resident #13 did not receive timely and appropriate wound care following a burn to the left thigh on 05/25/2022. The ALR provided no written evidence that staff received training on reporting incidents or treating burns. (See R373. II)

IV. The ALR failed to ensure ongoing and effective training on when to implement emergency procedures, as evidenced below:

Policy I-140 ...."Emergency Care" to assure adequate response to resident emergencies. Residents will receive appropriate emergency care and will have an emergency call system in their dwelling unit. Staff will be trained in first aid and cardiopulmonary resuscitation (CPR) for early management of problems. When in doubt, the emergency medical services system will be activated."... When the staff at the Community determines that, in its judgement, an emergency situation exists, staff will call 911."

Policy I-155 - "Summoning Help. When it is apparent that a resident is in need of medical help, the staff member will call the ambulance, 911, and notify the on-staff nurse. Stay with the resident until help arrives... Notify the Manager, who will in turn contact the family or responsible

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person."

A. On 06/29/2022 beginning at 12:54 PM, the Nurse Practitioner (NP) said during an interview that she was informed on 06/26/2022 that Resident #8 was taken to the emergency room for a stroke at 7:00 PM on the night before (06/25/2022). She further stated she did not know how long the resident was exhibiting signs and symptoms of stroke prior to the call for 911/Emergency Medical Services (EMS). According to the hospital discharge summary, the patient was outside the window for tissue plasminogen activator [tPA].

On 06/29/2022 at 3:00 PM, during an interview, LPN #1 stated that Resident #8 informed her on 06/25/2022 that he felt like he was having a stroke. LPN #1 assessed the resident's vital signs which she stated were within normal limits. Resident #8 then called his family members in North Carolina (early morning) to inform them that he thinks he is having a stroke. The family in North Carolina then called a local family member who eventually came to the facility later that day. The local family member requested that the ALR nurse call 911 due to slurred speech and left side weakness. LPN #1 acknowledged that she did not document the time that EMS arrived, nor did she document the time that EMS took the resident to the emergency room.

B. According to the NP, on 06/18/2022, LPN #6 called her three times regarding Resident #15. At 3:57 PM, the nurse informed the NP that the resident was "... a little confused and did not feel good." The nurse was not able to provide more information to the NP. At 6:44 PM, LPN #6 called the NP and informed her of the urine dipstick results and that the resident was trying to eat a

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sandwich but was not using her hands. At 8:01 PM, the LPN #6 called the NP to inform her that the paramedics were concerned that the resident may be having a stroke. The NP stated that she asked the LPN if the resident was having weakness on her left side, to which the LPN responded, "I think it got worse." The NP further stated that she asked the LPN if she performed a neurological assessment, to which LPN #6 admitted that she had not performed a complete assessment.

The investigation showed that Residents #8 and 15 experienced recent, significant health events (stroke symptoms) and the residents did not receive timely or appropriate emergency services. The ALR provided no written evidence that staff received training on emergency response policies and procedures (assessments, calling for an ambulance, etc.).

On 06/30/2022 at 11:55 AM, interview with the Director of Nursing (DON) revealed that she had conducted training with the staff [topics not specified] when a need was identified or through her observations. When asked for documentation to verify the training's, the DON admitted that she had not documented the training's she conducted.

On 07/01/2022 at 3:30 PM, review of the ALR's policy K-320 "Orientation and Training showed: "Orientation and training shall be provided to employees. The program will consist of the following... "Documentation (position appropriate), tasks of the positions, common diseases of the elderly, medication management (position appropriate), communication among staff, safety, emergency procedures (CPR, FA) policies and procedures (and other)." Policy K-330 titled

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R 129	Continued From page 26 "Ongoing Staff Training" included the following: "Participation in educational offerings and in-services will be taken into consideration at the time of performance appraisals. Educational offerings and in-services will be arranged and/or approved by the Manager or Supervisor. Continuing education should include the following: health, nutritional, aging, behavioral, cultural, dementia, functional, safety, regulatory, psychosocial, and other... " At the time of the investigation there was no evidence that the ALR provided ongoing training to ensure its staff demonstrated competency in medication management, maintaining medication administration records, identifying, reporting and recording significant changes in residents condition and implementing emergency procedures.	R 129		
R 373	10124.7 Medication Administration 10124.7 An ALR shall ensure that all medication administered to a resident by licensed practical nurse, registered nurse, advanced practice registered nurse, physician, physician assistant, TME, or certified medication aide on its premises shall be recorded on a written or electronic medication administration record that is kept as part of the resident's healthcare records. Based on interview and record review, the assisted living residence (ALR) failed to ensure that nurses consistently documented medication administration in each resident's Medication Administration Record, (MAR), for 9 of 17 residents in the core sample (Residents #1, 3, 5, 6, 7, 9, 10, 13 and 16). Findings included:	R 373		

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I. The ALR failed to ensure that all medications administered were documented on the resident's MAR, as evidenced below:

A. On 06/29/2022 at 10:14 AM, during an interview with the Nurse Practitioner (NP), she stated that she ordered Bactrim for Resident #13 to treat a second-degree burn. The NP did not think the resident received the medication. Review of Resident #13's MAR showed no evidence the resident received Bactrim for 10 days. Further investigation on 06/29/2022 at 4:00 PM, however, revealed that nurses documented in the resident's progress notes on 05/25/2022, 06/02/2022 and 06/03/2022 that they were administering the Bactrim.

During an interview on 06/29/2022, the Director of Nursing (DON) examined Resident #13's May 2022 and June 2022 MARS and acknowledged that the MARs did not show that the resident received the Bactrim.

B. On 06/29/2022 at 1:00 PM, during an interview with the NP, she stated that she ordered Oxycodone tab 5 mg tablet every 4 hours as needed for severe pain for Resident #16 on 05/24/2022 - 30 pills and on 06/22/2022 - 40 pills.

On 06/29/2022 at 2:45 PM, review of Resident #16's May 2022 MARs showed nurses documented twenty-six administrations of Oxycodone in May. The June 2022 MAR showed Oxycodone was administered six times.

On 06/29/2022 at 3:00 PM, review of Resident #16's narcotic count sheet revealed that the resident began receiving Oxycodone on 06/08/2022. The beginning count was 30 pills and

Medication Administration (373)

1. **A Medication Administration audit is conducted daily and reviewed in the Morning meeting to ensure compliance. The offending nurse is contacting to ascertain he reason for the infraction and counseled accordingly.**
2. **The licensed nurses will be education monthly on Medication administration. The daily/ weekly auditing of the resident records will continue.**
3. **The results of the audit will be reported in the QAPI committee meeting.**

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ending with 0 pills on 06/20/2022. The narcotic count sheet reflected 40 pills were on hand on 06/23/2022 at 6:45 PM, and 26 pills left on 06/29/2022 at 11:45 AM. The number of pills recorded on the narcotic count sheet were not consistent with the documentation on Resident #16's MAR.

During an interview on 06/29/2022 at 4:30 PM, the DON acknowledged that the MAR did not reflect that the licensed nurses signed the MARs when the resident received the Oxycodone.

II. The ALR failed to ensure treatments were documented on the MAR, as evidenced below:

The complainant alleged that Resident #13 sustained a burn to her leg in May 2022 and did not receive proper treatment.

On June 29, 2022, at 11:00 AM, interview with the NP revealed that she first learned of Resident#13's burn when the resident asked her if she needed to go to the hospital. The NP assessed the resident's burn and ordered Silvadene cream and Bactrim.

Review of Resident #13's MARs revealed the Silvadene cream was ordered on 05/25/2022 and discontinued on 06/12/2022. The investigation revealed that the Silvadene cream was not administered on 05/25/2022, 05/27/2022, 05/29/2022, 05/30/2022, and from 06/06/2022 through 06/11/2022.

It should be noted that although the nurses documented that the resident was receiving antibiotics in the progress notes, the MAR did not reflect the administration of the Bactrim.

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R 373	Continued From page 29 On 07/01/2022 at 6:23 PM, interview with the resident revealed that she wasted hot coffee on her leg and sustained the burn. Resident #13 said she told two nurses about the burn. After not receiving care, she treated the wound with Vaseline and covered it with toilet paper. She then informed the NP three days later, who ordered a cream and antibiotics. Interview with the DON confirmed that Resident #13 reported the injury to two nurses and the nurses did not relay the information to anyone or provide treatment. The DON said both nurses have been terminated. III. The ALR failed to ensure residents received prescribed medications as ordered, as evidenced below: 1. The complainant alleged that Resident #3 never received Levaquin (Levofloxacin) and Linezolid as prescribed on 04/11/2022. According to the NP, the resident brought Levaquin & Linezolid to the ALR after being discharged from the hospital for the nurses to administer. Review of the MAR, failed to show evidence that the medications were ever administered. On 6/30/2022 at 1:37 PM, review of Resident #3's hospital discharge summary dated 04/8/2022 revealed diagnoses that included left lower extremity cellulitis and bilateral leg edema. While in the hospital, the resident was prescribed Levofloxacin 750 mg by mouth daily and Linezolid 600 mg every 12 hours by mouth, which were to be continued at the ALR until 04/13/2022. At 1:52 PM, review of a 04/08/2022 progress note revealed that Resident #3 returned to the ALR from the hospital with Levofloxacin 750 mg daily	R 373		

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and Linezolid 600 mg po IQ 12 hrs. A 04/09/2022 progress note showed that Levofloxacin and Linezolid were maintained for the cellulitis without adverse reactions. There was no further mentioning of the two medications in the progress notes. Review of the medication administration records (MAR) failed document that the resident received the medications as prescribed after she was readmitted to the ALR.

Interview with the Assistant Director of Nursing (ADON) on 06/30/2022 at 2:05 PM revealed that after readmission, Resident #3 should have continued to receive the Levofloxacin 750 mg and Linezolid 600 mg until 04/13/2022, as prescribed. She confirmed however that the resident's records (MAR and the progress notes) did not document the administration of the two medications, as required.

2. The complainant alleged that Resident #10 did not receive a reduced dose of Januvia 50 mg daily for 5 days, followed by the previously prescribed 100 mg daily thereafter.

On 07/01/2022 at 1:00 PM, review of the progress note dated 5/26/2022 showed that ADON informed Resident #10's power of attorney of the critical lab results. The results revealed that the resident's glucose level was over 500 and her Hemoglobin A1c was 12.2. Following a discussion with the resident's care team, the resident acknowledged refusing Metformin for most of the month and said it caused worsening of her irritable bowel syndrome (IBS). The resident agreed to take Januvia 50 mg for five days, followed by 100 mg daily for one week. The resident also agreed to have a one-time finger stick with the nurse practitioner on 6/01/2022, to establish a baseline glucose level and to

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determine if the medications needed to be adjusted.

On 7/01/2022 at 8:37 AM, a review of Resident #10's medication orders revealed Januvia 50 mg, take 1 tab by mouth. Hold for blood glucose (BG) less than 200.

At 9:18 AM, the review of a 6/02/2022 progress note revealed that Januvia 100 mg was offered to Resident #10, however refused it and stated that she was supposed to receive Januvia 50 mg tablet, not 100 mg. Review of the MAR and the progress notes revealed no evidence the resident was offered Januvia 50 mg on or after 5/26/2022 for five days, or that the resident was administered Januvia 100 mg during this time. Januvia tab 100 mg was discontinued on 6/2/2022.

3. The complainant alleged that a COVID PCR swab was done for Resident #10 on 06/15/2022 and was never picked up by the Lab Corp. It was alleged that the DON had the key to the box and had put the swabs inside, however, did not call the lab for the pickup.

On 06/30/2022 at 1:37 PM, interview with the DON revealed that there had been a mix up regarding the key to the lab box and the COVID swabs done by the NP. She stated that both Resident #10 and the other resident's COVID swabs were repeated and that the results were negative.

III. The complainant alleged that Resident #5 was not administered Levothyroxine on 05/03/2022 through 05/10/2022, then again on 05/12/2022 and 05/13/2022, as ordered.

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On 06/29/2022 beginning at 11:36 AM, Resident #5's May 2022 MAR showed the following order: "Levothyroxine Tab 137 microgram, 1 tablet by mouth every morning at 6:00 AM. A review of the MAR showed no evidence that the medication was administered on 05/03/2022 through 05/10/2022, 05/12/2022 through 05/15/2022. The MAR showed Resident #5 did not receive the Levothyroxine on 13 of the first 19 days in May 2022.

It should be also noted that there was no evidence that nurses administered the Levothyroxine on 17 out of 30 mornings in April 2022. Resident #5's progress notes did not include any reason why the resident did not receive the Levothyroxine.

Review of the facility's policies and procedures manual failed to show evidence of written policies and procedures that would provide guidance regarding: (1) creating and maintaining a resident's monthly MAR, (2) facility nurses clarifying medication orders, or (3) nurses documenting the administration of each medication in a resident's record.

IV. The complainant alleged that Resident #5 missed entire medication administrations.

Resident #5's April 2022 MAR showed no evidence that she was administered the medications scheduled for 8:00 PM on 04/16/2022. The missed medications included: Atorvastatin 10 milligrams (mg) prescribed at bedtime to control Hyperlipidemia; Basaglar insulin 30 units injected subcutaneously to manage type 2 diabetes mellitus; Divalproex 250 mg prescribed twice daily to treat dementia; Donepezil 5 mg prescribed at bedtime to treat

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dementia and two antifungal treatments applied to her feet twice daily. The April 2022 MAR also showed no evidence that her blood glucose was checked at 6:00 PM on 04/16/2022, with no Novolog insulin injected, accordingly. There were no progress notes to provide an explanation.

On 06/30/2022 beginning at 2:29 PM, the DON acknowledged the findings in the resident's MARs. She stated that she had been training the nurses on maintaining accurate documentation. She was unable to provide a record of the training. Earlier, at 11:29 AM, the DON had informed surveyors that there was no documentation available for review to show that staff received training prior to her being hired in April 2022.

V. The complainant alleged that Resident #6's family reported that the resident did not receive medications on a Monday (date not provided). When the family member notified a nurse, the nurse allegedly told the family member that the resident would be on a different floor for the evening medication pass.

Review of Resident #6's MARs showed that the resident did not receive morning medications on 04/01/2022, 04/02/2022, 04/04/2022, 05/10/2022 and evening medications from 04/01/2022 through 04/04/2022 and 05/10/2022. There were no progress notes available to explain why medications were not administered.

VI. Nurses did not document the administration of an antibiotic in Resident #6's April 2022 MAR, as evidence below:

According to a progress note dated 04/27/2022, a Licensed Practical Nurse (LPN #6) informed

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Resident #6's daughter that the resident was being prescribed two new medications (Sertraline for depression and Bactrim for a urinary tract infection). On 04/28/2022 at 2:09 PM, another nurse (LPN #2) wrote: "Resident start (sic) on antibiotic treatment Sulfameth/Trimethoprim (Bactrim)800/600 mg times 10-days by mouth twice a day. First dose given at 8:00 AM with no adverse reaction noted ..." Another progress note dated 04/29/2022 stated the nurse administered Bactrim.

Resident #6's April 2022 and May 2022 MARs showed no evidence that Resident #6 received the Bactrim.

VII. Resident #6 was not administered Metformin 1000 milligram twice a day as ordered by the physician, as evidenced below:

Review of Resident #6's May 2022 MAR showed the resident was not administered Metformin at 8:00 AM on 05/06/2022. In a progress note, LPN #2 wrote "Hold for finger stick of 98 milligram per deciliter." The resident's physician's order sheet (POS) for May 2022 said: "Metformin Tab 1000 mg. Take 1 tablet by mouth twice a day." The physician order sheet (POS) did not indicate to perform finger sticks and the MAR did not reflect any finger sticks being documented. Resident #6's POS indicated that her diabetes was controlled by the administration of Metformin and eating a "diabetic diet ... no concentrated sweets."

On 06/30/2022 at 3:10 PM, LPN #2 was shown the 05/06/2022 progress note and Resident #6's May 2022 MAR. LPN #2 confirmed that she held the Metformin that morning. When asked about parameters on blood glucose levels, she acknowledged there were no parameters

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indicated on the orders or MAR.

In an email sent to Resident #6's primary physician on 07/07/2022, the surveyor asked how often should facility staff check the finger stick reading? Surveyors also requested the original order for Metformin (ordered 03/16/2020) and asked the physician whether she wanted staff to administer the Metformin twice a day, regardless of blood glucose levels. No additional information about Resident #6's Metformin and finger sticks was received.

VIII. Resident #5 was not administered Ciprofloxacin (Cipro-Antibiotic) HCL every 12 hours for 10-days as ordered by the physician, as follows:

Resident #5's April 2022 MAR and progress notes entered on 04/07/2022 documented that the resident was prescribed "Ciprofloxacin (Cipro-Antibiotic) HCL 500 mg Tab, take one tablet by mouth every 12 hours for 10-days (for disease of the appendix)." The MAR also showed that the resident was administered the first dose at 10:00 PM on 04/07/2022 and continued receiving the treatment for 17 doses (last dose administered at 8:00 AM on 04/15/2022). There was no progress note to explain why the resident did not receive the medication at 8:00 PM, as ordered. A progress note entered on 04/16/2022 at 8:23 AM indicated the facility was "awaiting pharmacy delivery." There were no further notes regarding Resident #5's Cipro and no evidence that the resident received the 10-day regimen.

The facility's DON was interviewed on 06/30/2022 beginning at 2:29 PM. When asked if the pharmacy had delivered 20 doses of Cipro for Resident #5, the DON said the pharmacy usually

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delivered Cipro in individual packets. Upon review of the MAR and progress notes, the DON stated that whoever administered the last packet of Cipro on the morning of 04/15/2022 should have called the pharmacy and documented making the call in a progress note. She acknowledged that the MAR failed to show that Resident #5 received the treatment for 10 days.

IX. On 06/30/2022 at 9:07 AM, review of Resident #7's medical record showed the resident had diagnoses that included acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, unspecified protein-calorie malnutrition, Type II Diabetes Mellitus w/o complications, chronic obstructive pulmonary disease, unspecified, human immunodeficiency virus (HIV) disease, cerebrovascular disease, major depressive disorder, suicidal ideation's, sleep apnea, arteriosclerotic heart disease of native coronary artery without angina pectoris, hypothyroidism, bipolar, schizoaffective disorder, syncope and collapse, orthostatic hypotension...

On 06/30/2022 beginning at 9:10 AM, review of Resident #7's April 2022, May 2022, and June 2022 Medication Administration Records (MARs) showed the following:

- Ferrous Sulfate (iron supplement) 325 mg was to be taken one tablet by mouth three times a day for anemia. The MAR showed that the medication was not administered on 04/05/2022, 05/10/2022, 05/11/2022, and 06/04/2022.

- Resident #7 was not administered the supplemental oxygen continuously every shift as ordered on 04/23/2022, 04/24/2022, 04/28/2002, 05/21/2022, and 05/22/2022.

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- Breo Ellipata (for Asthma) 100-25 mcg, inhale one puff daily. The May 2022 MAR showed that the medication was not administered on 05/05/2022, 05/10/2022, and 05/11/2022.

- Fluticasone 50 mcg spray (for Allergy), inhale one spray in each nostril daily. The MARs showed that the medication was not administered on 04/05/2022, 04/11/2022, and 05/10/2022.

- Metformin 1000 mg (for Diabetes), one tablet twice a day. The MAR showed that the medication was not administered on 04/05/2022.

- Resident #7's April 2022 and May 2022 MARs also showed no evidence that the resident received the following medications as ordered on 04/05/2022 and 05/10/2022: Etravirine 200 mg, Levothyroxine 137 mg, Omeprazole Capsule 20 mg, Prezista 600 mg, Ritonavir 100 mg, and SMZ/TMP DS TAB 800-600.

On 07/01/2022 beginning at 12:24 PM, the DON said during an interview that nurses were to document all medications administered on the MARs. When the surveyor showed the DON the missing documentation on Resident #7's MARs, the DON responded by saying "you're right, the documentation isn't there." The DON did not offer any reasons as to why nurses failed to document the administration of the medications, adding that she would re-educate the nursing staff on medication administration documentation.

2. The complainant alleged that the facility was not complying with Resident #7's order for continuous supplemental oxygen.

On 06/30/2022 beginning at 9:07 AM, review of

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R 373	Continued From page 38 Resident #7's medical record showed the resident's diagnoses included: acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, unspecified, cerebrovascular disease, and sleep apnea. Review of Resident #7's April 2022 and May 2022 MARs showed Resident #7 was not administered the supplemental oxygen continuously every shift as ordered on 04/23/2022, 04/24/2022, 04/26/2002, 05/21/2022, and 05/22/2022. X. On 06/30/2022 beginning at 1:17 PM, review of Resident #9's Service Plan dated 06/23/2022 showed the resident had diagnoses that included Hypertension, Diabetes Mellitus and Alzheimer's Disease. At 1:22 PM, review of Resident #9's order summary report dated 06/29/2022 showed the resident was prescribed Metoprolol Succinate 100 mg, Metformin 850 mg, Amlodipine Besylate 10 mg, Calcium/Vit D3 600mg/400 U Donepezil 5 mg, Jardiance 10 mg, Losartan POT 100 mg, Oxybutynin 10 mg, Pravastatin 20 mg, Rybelsus 14 mg and vitamin D3 Cap 2000 unit. At 1:33 PM, review of the June 2022, May 2022 and April 2022 MAR showed the following: - Metformin 850 mg, one tablet every evening for diabetes mellitus with diabetic chronic kidney disease. The June 2022 MAR showed that the medication was not administered on 06/30/2022 and 06/29/2022. The May 2022 MAR showed there were two duplicates of the Metformin on the MAR sheets. For example: a. Row one showed that Metformin was administered from 05/01/through 05/04/2022. The	R 373		

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same column also showed a discontinue date of 05/05/2022 for Metformin and the medications were not administered from 05/05/2022 through 05/31/2022.

b. Row two showed that Metformin was not administered on 05/01/2022 through 05/04/2022 but was administered from 05/05/2022 through 05/27/2022 and on 05/30/2022 and 05/31/2022.

The April 2022 MAR showed that the medication was not administered on 04/16/2022.

- Rybelsus 14 mg, one tablet every morning for diabetes mellitus with diabetic chronic kidney disease. The MAR showed that the medication was not administered on 06/30/2022, 06/29/2022, 05/30/2022, 05/10/2022, 05/05/2022, 05/04/2022, 05/03/2022, 05/02/2022 and 05/01/2022.

- Jardiance 10 mg, take one tablet by mouth every morning. The MAR showed that the medication was not administered on 06/30/2022, from 05/01/2022 through 05/11/2022 and on 05/30/2022.

- Amlodipine Besylate 10 mg, 1 tab once a day for hypertension. The MAR showed the medication was not administered on 05/30/2022 and 05/10/2022.

- Donepezil 5 mg, take 1 tab every evening for Dementia. The MAR showed the medication was not administered on 05/04/2022 and 05/16/2022.

- Losartan POT 100 mg, 1 tab every evening for hypertension. The MAR showed the medication was not administered on 04/20/2022, 04/21/2022 and 04/22/2022 (No BP/Pulse Check).

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- Oxybutynin 10 mg, 1 tab daily for overactive bladder. The MAR showed the medication was not administered on 05/10/2022, 05/30/2022, 04/20/2022, 04/21/2022, 04/22/2022 and 04/23/2022.

- Metoprolol Succinate ER 100 mg, 1 tab every evening for hypertension. The MAR showed the medication was not administered on 05/06/2022 through 05/26/2022 and on 05/30/2022 (No BP/Pulse Check).

- Pravastatin 20 mg, 1 tab at bedtime for Hyperlipidemia. The MAR showed the medication was not administered on 05/04/2022 and 04/16/2022.

- Calcium/Vit D3 600 mg/400 U, 1 tab twice a day. The medication was administered once on 05/10/2022, once on 05/30/2022 and once on 04/16/2022.

Continued review of the June 2022, May 2022 and April 2022 progress notes for the aforementioned dates failed to show evidence that the nurse documented the reasons for the missed medications in the progress notes.

On 07/01/2022 beginning at 12:24 PM, the DON said during a face-to-face interview that nursing staff administering medications were to document the medications administered on the MARs. When the surveyor showed the DON the missing documentation for June 2022, May 2022, and April 2022 MARs, the DON responded by saying "you're right, the documentation isn't there." The DON did not offer any reasons as to why the medications were not documented on the MAR. She stated that she would re-educate the nursing staff on medication administration documentation.

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R 373	Continued From page 41 XI. On June 29, 2022 beginning at 12:09 PM, review of Resident #1's MARs showed the following: - January 2022 MAR revealed there were no initials documented that indicated the resident was administered Pregabalin 50 mg during the morning medication administration on 01/12/2022 and 01/13/2022, during the midday administration on 01/12/2020 through 01/14/2022, and during the evening administration 01/12/2022. - March 2022 MAR revealed there were no initials documented that indicated the resident was administered Pregabalin 50 mg during the midday medication administration on 03/08/2022, 03/09/2022, 03/16/2022 and 03/24/2022. - April 2022 MAR revealed there were no initials documented that indicated the client was administered Pregabalin 50 mg during the midday medication administration on 04/05/2022. - May 2022 MAR show there were no initials documented that indicated the resident was administered Pregabalin 50 mg during the midday medication administration on 05/01/2022. Further review revealed there were no initials documented that indicated the resident's blood pressure and blood sugar levels were monitored on 05/18/2022 during the morning shift. - June 2022 MAR revealed there were no initials documented that indicated the resident was administered Pregabalin during the midday medication administration on 06/04/2022 and 06/9/2022. There were no initials that documented the resident was administered Bevespi Aerosphere 9-4.8 mcg on 06/17/2022	R 373		

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through 06/19/2022 during the morning and evening medication administration. Further review revealed there were no initials documented that indicated the resident's blood pressure and blood sugar levels were monitored on 06/25/2022 through 06/28/2022 and 06/30/2022 during the morning shift and 06/25/2022 through 06/30/2022 during the evening shift.

Continued review beginning on June 29, 2022, of Resident #1's MARs for January, March, April, May and June 2022, revealed that there was no information documented in the progress notes to explain why the initials were missing on the aforementioned dates.

Interview with the DON on 06/30/2022, at approximately 11:00 a.m., revealed that the MARs required an initial when medication is administered and a written explanation in the progress notes when medication is not given. The DON also stated that the LPN's are responsible for documenting the residents' blood pressure and blood sugar levels on the MARs.

XII. On 06/29/2022 beginning at 2:00 PM, review of Resident #1's progress notes dated 06/24/2022, revealed the DON documented that Resident #1 was ordered Azithromycin. According to the note, the aforementioned medication was not ordered through the facility pharmacy, therefore it was not transcribed in the facility's internal system.

Review of the POS failed to show an order for Azithromycin and review of the MARs failed to show the resident was administered Azithromycin.

Interview with Licensed Practical Nurse # (LPN) revealed that Resident #1 was administered

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R 373	Continued From page 43 Azithromycin, but she did not document the MAR to show when the medication was administered.	R 373		