STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-092-22	A. BUILDING: _____ B. WING _____	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EAST TOWER AT CARDINAL NORTH HILLS	320 ST ALBANS DRIVE RALEIGH, NC 27609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services of conducted an initial survey on 10/10/23 to 10/11/23.	D 000		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure staff had been competency validated for licensed health professional support (LHPS) tasks by return demonstration for 3 of 3 staff related to a resident	D 161		

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D 161	Continued From page 1 (#3)who required catheter care. The findings are: Review of resident #3's current FL-2 dated 07/03/23 revealed a diagnosis of atrial fibrillation, stroke, high blood pressure, and urinary retention. Attempt telephone interview on 10/11/23 at 3:55pm Resident #3's first home health nurse was unsuccessful. 1. Review of Staff A's personnel records revealed: -Staff A's hire date was 09/01/23 as a personal care aide (PCA). -There was no documentation Staff A had completed a LHPS Validation. Interview with Staff A on 10/11/23 at 10:00am revealed: -She worked 1st shift as a PCA from 7:00am to 3:00pm. -She had not been checked off for LHPS Validation for foley care since hire. -Second shift staff changed Resident #3's leg bag to a foley bag before bedtime. -Third shift staff changed the foley bag to a leg bag before the resident got out of bed for the day. -She only emptied the resident's foley bag and documented his urine output. Refer to interview with the Administrator on 10/11/23 at 5:00pm. Refer to interview with the Resident Care Manager (RCM) on 10/11/23 at 9:30am and at 12:00pm. Refer to interview with the current Home Health	D 161		

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D 161	Continued From page 2 RN on 10/11/23 at 4:00pm. 2. Review of Staff B's personnel records revealed: -Staff B's hire date was 09/19/23 as a medication aide (MA) and PCA. -There was no documentation Staff B had completed a LHPS Validation. Interview with Staff B on 10/11/23 at 3:00pm revealed: -She worked second shift (3:00pm-11:00pm). -She had not been checked off for LHPS Validation for foley care since hire. -She cleaned the tip of Resident #3's foley catheter tubing with disinfectant wipes. -She did not say who instructed her to clean the foley catheter tubing using disinfectant wipes. -She cleaned the catheter bags with running tap water. -She also emptied the resident's foley bag and documented his urine output. Refer to interview with the Administrator on 10/11/23 at 5:00pm. Refer to interview with the Resident Care Manager (RCM) on 10/11/23 at 9:30am and at 12:00pm. Refer to interview with the current Home Health RN on 10/11/23 at 4:00pm. 3. Review of Staff C's personnel records revealed: -Staff C's hire date was 06/11/23. -There was no documentation Staff C had completed a LHPS Validation. Staff C was not available for interview.	D 161		

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D 161	Continued From page 3 Refer to interview with the Administrator on 10/11/23 at 5:00pm. Refer to interview with the Resident Care Manager (RCM) on 10/11/23 at 9:30am and at 12:00pm. Refer to interview with the current Home Health RN on 10/11/23 at 4:00pm. _____ Interview with the Administrator on 10/11/23 at 5:00pm revealed: -There were 2 of 11 staff who provided catheter care for Resident #3 that had completed their LHPS validation. -She was responsible for ensuring that the LHPS validations had been completed. -Staff should not be performing tasks that they have not been validated to perform. -There was no process in place to audit for compliance. Interview with the Resident Care Manager (RCM) on 10/11/23 at 9:30am and at 12:00pm revealed: -The direct care staff did not perform routine catheter care. -They only clean the foley catheter if soiled during incontinent care. -Staff changed the catheter leg bag to a regular catheter bag and back to a catheter leg bag in the morning. -A new bag was not used each time it was changed. -The staff used the same catheter bags until the home health nurse replaced them. -The home health nurse came weekly and changed the catheter bags. -The staff rinsed the catheter bags with water	D 161		

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D 161	Continued From page 4 only after use and hung them to dry. -They did not have an order to clean the catheter before connecting the catheter bag. -There was not an order to use vinegar to clean the catheter bags. Interview with current Home Health RN on 10/11/23 at 4:00pm revealed: -She had only seen Resident #3 once to admit him to their services. -She had not completed any staff education regarding foley catheter care. -She was not aware the facility direct care staff used white vinegar to clean the foley bags or that they used disinfectant wipes to clean the tubing that connected the foley bags to the catheter. -Using white vinegar and disinfectant wipes were not a method of catheter care used or taught by her home health agency. -She was scheduled to return on 10/29/23 to change resident #3's foley catheter.	D 161		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by:	D 234		

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D 234	Continued From page 5	D 234		

Based on record reviews and interviews the facility failed to ensure 2 of 3 residents sampled (Residents #1 and #3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.

The findings are:

1. Review of resident #3's current FL-2 dated 07/03/23 revealed a diagnosis of atrial fibrillation, stroke, high blood pressure, and urinary retention.

Interview with the Resident Care Manager (RCM) on 10/10/23 at 11:30am revealed she provided the move in date for Resident #3 as 07/24/23.

Review of resident #3's record for tuberculosis (TB) skin test revealed there was documentation of his first TB skin test on 07/03/23 and read as negative on 07/05/23.

Review of resident #3's record for tuberculosis (TB) skin test revealed there was no documentation of a second TB skin test for Resident #3.

Interview with the RCM on 10/11/23 at 1:50pm revealed Resident #3 was required to have an initial TB skin test before he moved in and should have obtained the 2nd TB skin test within 2 weeks of the 1st TB skin test.

Refer to interview with the RCM on 10/11/23 at 1:52pm.

Refer to interview with the Administrator on 10/11/23 at 2:16pm.

2. Review of Resident #1's current FL-2 dated

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D 234	Continued From page 6	D 234		

07/14/23 revealed diagnoses included rheumatoid arthritis, hyperthyroidism, pacemaker, chronic pain syndrome, osteoarthritis, peripheral artery disease, fusion of spine, and sacral decubitus ulcer.

Review of the Resident #1's Resident Register revealed Resident #1 was admitted on 07/12/23.

Review of Resident #1's Resident Register revealed the resident lived at home prior to moving into the facility.

Review of Resident #1's record for a tuberculosis (TB) skin test revealed there was no documentation of a first or second TB skin test having been administered.

Interview with the Administrator on 10/11/23 at 2:15pm revealed:
-Resident #1's family was contacted on 10/11/23 to determine if a TB test had been done previously.
-He contacted Resident #1's previous facility for possible two TB skin tests documentation prior to admission, and the previous facility had documentation of one TB skin test administered on 05/17/21.
- A follow up audit/ review was not completed on Resident #1's file upon admission.

Refer to interview with the Resident Care Manager (RCM) on 10/11/23 at 1:52pm.

Refer to interview with the Administrator on 10/11/23 at 2:16pm.

_____

Interview with the Resident Care Manager (RCM) on 10/11/23 at 1:52pm revealed:
-A 2 step TB skin test was to be completed before

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D 234	Continued From page 7 the resident moved in, this was the move in policy. -She was responsible for making sure the 2-step TB test was completed prior to admission. -Residents were not allowed to move in without the required documentation of a TB skin test, x-ray if past positive TB skin test, or QuantiFERON gold lab test. Interview with the Administrator on 10/11/23 at 2:16pm revealed: -The RCM was responsible for ensuring each resident had a 2 step TB skin test. -An audit was performed on admission to ensure each resident had a TB skin test; no follow up audit was performed. -Residents were not allowed to move in without a TB skin test or QuantiFERON gold lab test. -A follow-up audit and review should be completed upon a resident moving into the facility to ensure all documents are completed. -She did not explain why the residents were admitted without having completed the TB skin test or QuantiFERON gold lab test before they were admitted to the facility.	D 234		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register (b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the information on the form as needed. The Resident Register is available on the internet	D 248		

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website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed within 72 hours of admission to the facility for 3 of 3 sampled residents (#1, #2, and #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 07/14/23 revealed diagnoses included rheumatoid arthritis, hyperthyroidism, pacemaker, chronic pain syndrome, osteoarthritis, peripheral artery disease, fusion of spine, and sacral decubitus ulcer.

Review of Resident #1's record revealed she was admitted on 07/12/23.

Review of Resident #1's Resident Register had not been signed by the Administrator or designee.

Refer to the interview with the Administrator on 10/11/23 at 2:20pm.

2. Review of Resident #2's current FL-2 dated 07/01/23 revealed diagnoses included Parkinson's disease, coronary artery disease, cardiac stents, insulin dependent diabetes mellitus, hyperlipidemia, and mitral regurgitation.

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D 248	Continued From page 9 Review of Resident #2's record revealed he was admitted on 07/07/23. Review of Resident #2's Resident Register dated 07/07/23 had not been signed by the Administrator or designee. Refer to the interview with the Administrator on 10/11/23 at 2:20pm. 3. Review of Resident #3's resident register on 10/10/23 at 12:25 pm revealed that the document had not been signed by the Executive Director or authorized designee. Review of Resident #3's resident register on 10/10/23 at 12:25 pm revealed a resident register with a signature from the power of attorney and was dated 06/27/23. Interview with the Resident Care Manager (RCM) on 10/10/23 at 11:30 am revealed she provided the move in date of 07/24/23. Review of the staff notes dated 07/28/23 at 9:58 pm revealed a medication aide (MA) documented a move in note for day 2. Refer to the interview with the Administrator on 10/11/23 at 2:20pm. _____ Interview with the Administrator on 10/11/23 at 2:20pm revealed: -She did not know the Resident Register had to be signed by the Administrator or Administrator in charge within 72 hours of the residents admission to the facility. -The Resident Care Manager (RCM) was	D 248		

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D 248	Continued From page 10 responsible for ensuring the Resident Registers were completed.	D 248		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a care plan was completed within 30 days of admission to the facility for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/14/23 revealed diagnoses included rheumatoid arthritis, hyperthyroidism, pacemaker, chronic pain syndrome, osteoarthritis, peripheral artery disease, fusion of spine, and sacral decubitus ulcer. Review of Resident #1's Resident Register revealed she was admitted on 07/12/23. Review of Resident #1's care plan had not been signed by the physician.	D 263		

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D 263	Continued From page 11 Refer to interview with the Administrator on 10/10/23 at 11:15am. 2. Review of Resident #2's current FL-2 dated 07/01/23 revealed diagnoses included Parkinson's disease, coronary artery disease, cardiac stents, insulin dependent diabetes mellitus, hyperlipidemia, and mitral regurgitation. Review of Resident #2's Resident Register revealed he was admitted on 07/07/23. Review of Resident #2's care plan dated 08/07/23 had not been signed by the physician. Refer to interview with the Administrator on 10/10/23 at 11:15am. 3. Review of resident #3's current FL-2 dated 07/03/23 revealed a diagnosis of atrial fibrillation, stroke, high blood pressure, and urinary retention. Interview with the Resident Care Manager (RCM) on 10/10/23 at 11:30 am revealed she provided the move in date for Resident #3 as 07/24/23. Review of Resident #3's record on 10/10/23 at 12:25 pm revealed there were 2 care plans dated 07/24/23 and 08/29/23 and neither care plan had been signed by the physician. Refer to interview with the Administrator on 10/10/23 at 11:15 am. _____ Interview with the Administrator on 10/10/23 at 11:15 am revealed: -She was not aware the care plans had to be signed by the physician.	D 263		

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D 263	Continued From page 12 -The care plans for the facility were not signed by a physician.	D 263		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure follow-up on a speech therapy (ST) evaluation to meet the health care needs of 1 of 3 residents sampled (#1). The findings are: Observation of Resident #1 on 10/11/23 at 8:25am during the medication administration pass revealed: -The medication aide (MA) had 3 plastic medication cups; 1 with crushed medications mixed with chocolate pudding, 1 with an orange tablet and a clear capsule which contained tan colored granules and one with a red crystal covered gummy. -Resident #1 was seated in her wheelchair at her bathroom vanity. -There was a small 8-ounce water bottle about 1/3 full of water on the vanity. -The water bottle had a plastic straw in it. -The MA gave Resident #1 the crushed medications mixed in the chocolate pudding and offered Resident #1 the water bottle from the vanity. -Resident #1 grimaced and expressed strong distaste when the medications were in her mouth	D 273		

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and ceased once the medications had been swallowed with water that she drank from a straw in an 8-ounce water bottle.
-The MA then gave Resident #1 the orange tablet and the capsule from the second medication cup.
-The water bottle contained a very small amount, and the MA asked the private duty aide to bring another water bottle from the kitchen.
-Resident #1 said she needed more water that the medications were "stuck" and pointed at her throat.
-The MA offered Resident #1 more water and Resident #1 swallowed the tablet and capsule without any further problem.
-The MA gave Resident #1 the third cup with the red crystal covered gummy which Resident #1 chewed and swallowed without difficulty and drank more water when she swallowed.

Review of Resident #1's current FL-2 dated 07/14/23 revealed diagnoses included rheumatoid arthritis, hyperthyroidism, pacemaker, chronic pain syndrome, osteoarthritis, peripheral artery disease, fusion of spine, and sacral decubitus ulcer.

Interview with Resident #1 on 10/11/23 at 8:28am revealed:
-She did not like having her medications crushed because they tasted bad.
-She preferred to be able to swallow them whole.
-At one time she had a problem swallowing them because of a sore throat.

Review of Resident #1's Resident Register revealed she was admitted on 07/12/23.

Review of Resident #1's care plan did not include any information regarding the resident's diet.

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D 273	Continued From page 14 Review of Resident #1's Physician's Office Visit Form dated 08/04/23 revealed: -Resident #1 was seen because she had complained of a sore throat. -There was an order for a mechanical soft diet. -There was an order to crush medications mix with apple sauce or pudding. -There was an order for Speech Therapy to evaluate. Review or Resident #1's Care Tracking Log dated 08/04/23 revealed: -The entry note was completed by the Resident Care Manager (RCM). -Resident orders for speech therapy (ST) evaluation and treat were faxed to the home health agency. Review of Resident #1's Physician Office Visit Form dated 08/25/23 revealed an order for Home Health Speech Therapy (HHST) to evaluate and treat and to evaluate diet. Review or Resident #1's Care Tracking Log dated 08/04/23 revealed: -The entry note was completed by the Resident Care Manager (RCM). -Resident orders for speech therapy (ST) evaluation and treat were faxed to the home health agency. Review of Resident #1's Care Tracking Log dated 08/25/23 revealed: -The entry note was completed by the RCM. -Resident #1 requested to be changed from a (mechanical soft diet) soft and bite size diet to a regular diet. -Resident #1 was advised a Speech Therapy (ST) evaluation was needed before the order to change the resident's diet could be changed.	D 273		

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-The RCM notified the home health agency of PCP order for a speech therapy evaluation.

Interview with a Home Health Agency (HHA) staff member on 10/11/2023 at 11:50am revealed:
-The HHA received an order to evaluate and treat and to evaluate diet for Resident #1 on 08/25/23.
-A ST consult was attempted on 09/07/23.
-It was documented that Resident #1 had refused to have the ST evaluation done.

Second interview with Resident #1 on 10/11/23 at 3:05pm revealed:
-There was one incident of her "pills getting stuck" when she swallowed them because she did not have enough water.
-"Everyone had pills to get stuck at least once" but that did not mean she needed them crushed.
-She would like to take her medications whole and did not want her food chopped.
-"I'm not a baby": I want my French fries whole not cut up in small pieces.
-She denied having a speech therapy evaluation and denied declining services and said, "why would I do that."

Interview with personal care aide (PCA) on 10/11/23 at 11:09am revealed:
-She worked with Resident #1 since the resident moved into the facility in July 2023.
-Approximately one month after Resident #1 moved into the facility, the PCA noticed the resident had "choked" while taking her medications.
-She reported the resident's choking to the RCM.
-Resident #1 received a doctor's order to crush her medications and to change her diet to mechanical soft in bite size pieces.

Interview with the Administrator on 10/11/23 at

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D 273	Continued From page 16 2:20pm revealed: -The MAs and the RCM were responsible for ensuring the PCP orders were done. -Any referral to an outside agency would be done by the RCM. -Resident #1 had no current issues with choking to her knowledge. -She thought the home health (HH) agency had sent the speech therapist out to evaluate Resident #1. -Not all the HH staff wrote progress notes and left them at the facility. -She tried to request the HH notes but they were required to send a release of information to the Power of Attorney to get a release signed.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents observed during the medication pass including errors with a medication used to treat depression and a sublingual vitamin supplement used to treat dementia, heart disease, stroke, and osteoporosis (#1) and 1 of 3 sampled residents which the staff provided catheter care for an	D 358		

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D 358	Continued From page 17 indwelling catheter without an order (#3). The findings are: The medication error rate was 7% as evidenced by two errors out of 27 opportunities during the 8:00am/9:00am medication pass on 10/11/23. 1. Observation of Resident #1 on 10/11/23 at 8:25am during the medication pass revealed: -Resident #1 had medications that were to be crushed as well at one tablet and one capsule that were to be swallowed whole, three vitamin tablets that were to be given under the tongue to dissolve (SL- sublingual) and one gummy vitamin that she was to chew and swallow. -The medication aide (MA) removed the medications for Resident #1 from the medication cart and compared the medication label on the medication card with the information on the computer screen. -The MA proceeded to pop the medications from their cards into a plastic medication cup. -She placed the gummy vitamin into a separate plastic cup. -She placed the capsule from the original bottle into a separate plastic cup. -She took the remaining medications and transferred them from the plastic cup into a plastic envelope to use with the medication crusher. -She placed the plastic envelope into the crushing device and the surveyor stopped her before she crushed the enclosed medications so as not to waste all the medications from the one medication that was not to be crushed. -This medication was Pristiq (a medication used to treat depression). -The medication label for Pristiq contained two red pharmacy labels: 1-documented "TAKE IN	D 358		

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D 358	Continued From page 18 THE MORNING" and 2-documented "DO NOT CHEW OR CRUSH, SWALLOW WHOLE". -The administration instructions on the computer screen were to take one tablet by mouth once daily "DO NOT CRUSH." -She removed the Pristiq (orange tablet) and placed it in the plastic medication cup with the capsule. -She returned to the crushing device and crushed the remaining tablets to include the three vitamin supplements that were ordered to be given sublingually. -She took the crushed medications and mixed them with a plastic spoon into a plastic cup which contained chocolate pudding. -The MA had three plastic medication cups; one with crushed medications mixed with chocolate pudding, one with an orange tablet and a clear capsule which contained tan colored granules and one cup with a red crystal covered gummy and proceeded to Resident #1's room. -Resident #1 was seated in her wheelchair at her bathroom vanity. -There was a small 8-ounce water bottle about one-third full of water on the vanity. -The water bottle had a plastic straw in it. -The MA gave Resident #1 the crushed medications mixed in the chocolate pudding with the plastic spoon and offered Resident #1 the water bottle from the vanity. -Resident #1 grimaced and expressed strong distaste when the medications were in her mouth and ceased once the medications had been swallowed with water that she drank from a straw in an 8-ounce water bottle. -The MA then gave Resident #1 the orange tablet and the capsule from the second medication cup. -The water bottle contained only a small amount, and the MA asked the private duty aide to bring another water bottle from the kitchen.	D 358		

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-Resident #1 said she needed more water that the medications were "stuck" and pointed at her throat.
-The MA offered Resident #1 more water and Resident #1 swallowed the tablet and capsule without any further problem.
-The MA gave Resident #1 the third cup with the red crystal covered gummy which Resident #1 chewed and swallowed without difficulty and drank more water when she swallowed.

Review of Resident #1's current FL-2 dated 07/14/23 revealed:
-Diagnoses included rheumatoid arthritis, hyperthyroidism, pacemaker, chronic pain syndrome, osteoarthritis, peripheral artery disease, fusion of spine, and sacral decubitus ulcer.
-There was an order for Vitamin B-12 3000 mcg (a dietary supplement that lowers Homocysteine an amino acid linked to dementia, heart disease, stroke, and osteoporosis) take one sublingual every day.
-There was no order for Pristiq (desvenlafaxine).

Review of Resident #1's physician's order dated 08/03/23 revealed an order to start Pristiq 50mg 1 tablet once a day.

Review of Resident #1's physician's order dated 08/31/23 revealed an order to change Pristiq to 100mg 1 tablet once a day.

Review of Resident #1's Resident Register revealed she was admitted on 07/12/23.

Review of the Pfizer website (www.pfizermedinfo.com) for administration directions of Pristiq (desvenlafaxine) revealed:
-Pristiq was indicated for the treatment of major

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depressive disorder, including the prevention of relapse.
-Pristiq should be taken at the same time each day.
-Tablets must be swallowed whole with a glass of water or other nonalcoholic liquid and not divided, crushed, chewed, or dissolved.
-As the tablet travels the length of the gastrointestinal tract, the active ingredient desvenlafaxine was slowly released and if crushed could cause the medication to be absorbed into the patient's body too quickly.

Review of Resident #1's Physician's Office Visit Form dated 08/04/23 revealed:
-Resident #1 was seen because she had complained of a sore throat.
-There was an order for a mechanical soft diet.
-There was an order to crush medications and mix with apple sauce or pudding.
-There was an order for Speech Therapy to evaluate.

1. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Pristiq 100mg ER one time a day scheduled for 9:00am and *DO NOT CRUSH* was included in the entry.
-Pristiq was documented as administered daily from 10/01/23 - 10/11/23.
-There was an entry dated 08/04/23 may crush appropriate meds and put in applesauce or pudding if needed.

2. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for B-12 1000mcg dissolve 3 tablets sublingually (under the tongue) once daily.

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D 358	Continued From page 21 -Vitamin B-12 was documented as administered daily from 10/01/23 - 10/11/23. -There was an entry dated 08/04/23 may crush appropriate meds and put in applesauce or pudding if needed. Interview with Resident #1 on 10/11/23 at 8:28am and 3:05pm revealed: -She did not like having her medications crushed because they tasted bad. -She preferred to be able to swallow them whole. -She had one time had a problem swallowing them because of a sore throat. -There was one incident of her "pills getting stuck" when she swallowed them because she did not have enough water. -"Everyone had pills to get stuck at least once" but that did not mean she needed them crushed. -She would like to take her medications whole and did not want her food chopped. -"I'm not a baby": I want my French fries whole not cut up in small pieces. -She denied having a speech therapy evaluation and denied declining services and said, "why would I do that." Interview with personal care aide (PCA) on 10/11/23 at 11:09am revealed: -She worked with Resident #1 since the resident moved into the facility in July 2023. -Approximately one month after Resident #1 moved into the facility, the PCA noticed the resident had "choked" while taking her medications. -She reported the resident's "choking" to the RCM. -Resident #1 received a doctor's order to crush her medications and to change her diet to mechanical soft in bite size pieces.	D 358		

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D 358	Continued From page 22 Interview with the MA on 10/11/23 at 11:44am revealed: -She had been crushing Resident #1's medications since they had received the order to crush them. -She did not know if the facility had a "Do Not Crush" (DNC) list. -She worked at the facility for 2 months and had never seen a DNC list. -She had not noticed the red sticker on the medication card. -She knew from her medication aide training there were certain medications that should not or could not be crushed. -She did her "checks" with the medication card against the computer but had not noticed the "DO NOT CRUSH." -Resident #1 drank only the water from the little water bottles and she preferred the water to be at room temperature. -The resident had always complained about the crushed medications tasting nasty. -She knew Resident #1 was supposed to be seen by Speech Therapy (ST) but had not seen ST come in to see Resident #1. Interview with the Administrator on 10/11/23 at 2:20pm revealed: -The MAs should read all the labels on the medication cards and compare them to the full instructions on the computer. -The MAs should never crush any medication that has it labeled DO NOT CRUSH. Telephone interview with Resident #1's primary mental health care provider on 10/11/23 at 2:50pm revealed: -Resident #1 has been taking Pristiq to help with her depression. -The effects of Pristiq when crushed would give	D 358		

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Resident #1 a "dump" of the medication instead of releasing it slowly into her system.
-If Pristiq had been crushed since 08/04/23, Resident #1 would not have been getting the full desired effects of Pristiq which was started at 50mg on 08/03/23.
-She had increased the dosage of Pristiq from 50mg to 100mg on 08/31/23.
-She would expect the MAs to follow the direction of the pharmacy for medications that cannot be crushed.

Telephone interview with Resident #1's primary care provider (PCP) on 10/11/23 at 3:31pm revealed:
-Resident #1 was ordered Vitamin B-12 due to her blood work that had shown her to be deficient.
-The Vitamin B-12 was ordered to be given sublingual (SL) (under the tongue) since it was absorbed better under the tongue through vascular absorption than swallowing it and trying to have it absorbed through the gastrointestinal tract.
-Resident #1 would not be getting the full effects of the Vitamin B-12 by crushing it and mixing it with food but there were no adverse effects from it being given that way.

2. Review of resident #3's current FL-2 dated 07/03/23 revealed a diagnosis of atrial fibrillation, stroke, high blood pressure, and urinary retention.

Interview with Resident #3 on 10/11/23 at 8:55am revealed:
-He had to call staff when he needed his catheter bag emptied.
-He had to call a home health nurse when he needed his catheter changed or had any problems.

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D 358	Continued From page 24 -He had been to the emergency department (ED) 5 times for catheter problems. -The staff changed his catheter leg bag in the evening to a regular catheter bag and then back to a catheter leg bag the next morning. -The staff cleaned the catheter bag with white vinegar and placed it in a plastic bag to dry and it was reused. Interview with a personal care assistant (PCA) on 10/11/23 at 10:00am revealed: -She had not changed the catheter bags. -Evening shift had changed the catheter leg bag to a regular catheter bag and the night shift changed the catheter bag back to a catheter leg bag. -Dayshift measured his urine at the end of the shift. Interview with a medication aide (MA) on 10/11/23 at 2:55pm revealed the RCM instructed the MA that he was to use white vinegar to clean catheter tubing and catheter bag when the catheter bags were changed. Interview with a second MA on 10/11/23 at 3:00pm revealed: -She had cleaned the tip of the catheter tubing with disinfectant wipes. -The catheter bags were cleaned with water. -The urinal that was used to measure his output was cleaned with vinegar. Interview with a third MA on 10/11/23 at 3:10pm revealed: -During shift report, it was passed on to use white vinegar to clean the catheter bags after they were changed. -MA had not cleaned the tip of the catheter tubing before she connected the catheter bag.	D 358		

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D 358	Continued From page 25 Interview with the Resident Care Manager (RCM) on 10/11/23 at 9:30am and 12:00pm revealed: -The staff do not perform routine catheter care. -They only clean if soiled during incontinent care. -Staff changed the catheter leg bag to a regular catheter bag and back to a catheter leg bag in the morning. -A new bag was not used each time it was changed. -The staff used the same 2 catheter bags until the home health nurse replaced them. -The home health nurse came weekly and changed the catheter bags. -The staff rinsed the catheter bags with water only after use and hung them to dry. -They did not have an order to clean the catheter before connecting the catheter bag. -There was not an order to use vinegar to clean the catheter bags. Interview with the Administrator on 10/11/23 at 2:20pm revealed: -Soap and water were used for catheter care when hygiene, incontinent care, and showering was performed. -The tip of the catheter tubing was to be cleaned with alcohol before the catheter bag was connected. -A new catheter bag was not used each time the catheter bag was changed from a catheter leg bag to a regular catheter bag, it was up to the home health nurse to replace the used catheter bags with new catheter bags. -White vinegar was not used to clean catheter bags. Review of the facility catheter care policy with an effective date of 05/2012 revealed: -Nurses should educate non-licensed personnel	D 358		

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in correct techniques of catheter care.
-Clean the end of spout using rubbing alcohol on a gauze pad or cotton ball.
-Cleaning and changing of the drainage bag should be performed per physician/prescribing practitioner's orders.

Review of staff chart notes dated 09/12/23 at 1:19pm by RCM Revealed:
-She had spoke with Resident#3's primary care provider regarding clarifying a previous order from another provider for urinary output to be reordered at the end of each shift and as needed as well as an order to wash urine bag with vinegar and water daily.

Review of Resident #3's September 2023 Medication Administration Record (MAR) on 10/11/23 at 12:00pm revealed:
-There was an order written that foley bag was to be cleaned with water and vinegar per Cardinal Protocol on 09/12/23 at 2:00pm.
-Order was canceled as incorrect order on 09/13/23 at 11:00am and no new order was written to clean the foley bag.

Review of physician orders revealed:
-There was not an order to change the urinary catheter bags.
-There was not an order to use white vinegar to clean the used urinary catheter bags.

Attempt to interview on 10/11/23 at 9:00am Resident #3's primary care provider was unsuccessful.