STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop an accurate and individualized care plan in the area of [MEDICAL CONDITION] medications for 1 of 3 residents (Resident #3) reviewed for unnecessary medications. The findings included: Resident #3 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED].#3 indicated Quetiapine [MEDICATION NAME] (antipsychotic medication) 25 milligrams (mg) twice daily for delusions. A physician's order [REDACTED].#3 ' s Quetiapine [MEDICATION NAME] and initiated [MEDICATION NAME] (antipsychotic medication) 7.5 mg in the evening for [MEDICAL CONDITION]. A psychiatry progress note dated 8/24/20 indicated Resident #3 was prescribed [MEDICATION NAME] for the [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 ' s cognition was intact, and she received antipsychotic medication on 7 of 7 days. Resident #3 ' s active care plan, last reviewed on 9/18/20, included the focus area, The resident is on antipsychotic therapy for depression. This focus area was created by the MDS Nurse. Resident #3 ' s active physician's order [REDACTED]. An interview was conducted with the MDS Nurse on 10/1/20 at 8:08 AM. Resident #3 ' s care plan that indicated she was on antipsychotic medication for depression was reviewed with the MDS Nurse. The MDS Nurse revealed this care plan was inaccurate. She acknowledged that Resident #3 ' s antipsychotic medication was prescribed for management of hallucinations and delusions. She stated that she had not recalled entering this care plan for Resident #3. The MDS Nurse indicated she must have hit the wrong drop down box which incorrectly put depression as the [DIAGNOSES REDACTED]. During a phone interview with the Director of Nursing (DON) on 10/1/20 at 9:55 AM she indicated that her expectation was for care plans to be accurate and individualized.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to review and revise a care plan in the area of medication for 1 of 3 residents reviewed for unnecessary medications. (Resident #1) The findings included: Resident #1 was initially admitted to the facility 5/15/17 and most recently readmitted [DATE] with [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1's cognition was fully intact. She was not coded for receiving an antipsychotic medication during the MDS review period. A review of the August 2019 Medication Administration Record [REDACTED]. Resident #1's care plan revealed a focus area of antipsychotic therapy related to delusions. This focus area was initiated on 10/15/19 and most recently reviewed on 9/3/20. On 10/1/20 at 11:08 AM an interview occurred with the MDS Coordinator. After reviewing Resident #1's medical record, she confirmed the resident received an antipsychotic medication in the form of [MEDICATION NAME] until 8/4/20. The MDS Coordinator added the care plan for antipsychotic therapy should have been resolved when the review was completed on 9/3/20. An interview occurred with the Executive Director and Director of Nursing on 10/1/20 at 2:30 PM. The both indicated it was their expectation for the care plan to be an accurate representation of the resident.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to prevent a dependent resident from rolling out of bed onto the floor, hitting her head on a nightstand, and becoming wedged between the bed and the nightstand during a bed bath. Resident #1 sustained a laceration to her head requiring staples as well as multiple skin tears to her left lower extremity. This was for 1 of 3 residents reviewed for accidents (Resident #1). The findings included: Resident #1 was initially admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 ' s care plan with a review of date of 7/21/20 included the following focus areas: - The risk for falls related to decreased physical function (initiated on 7/15/19). The interventions included, in part, ensuring Resident #1 ' s call light was within reach and encouraging her to use it for assistance as needed (initiated on 7/15/19). A Transfer/Mobility Status Criteria assessment form dated 8/13/20 indicated Resident #1 required extensive assistance to total dependence. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact. She required extensive assistance of 1 for bed mobility, she was dependent of 1 for dressing and toileting, and dependent of 2 or more for transfers. Resident #1 had impaired range of motion on one side of her lower extremities. She had no falls noted. A hard copy form, Report of Resident Fall, dated 9/2/20 completed by Nurse #2 indicated Resident #1 had a fall with injury that was witnessed by Nursing Assistant (NA) #1 at 11:45 AM. Resident #1 rolled out of bed while staff (was) cleaning resident. The resident was on the floor on her left side wedged between her bed and nightstand. Resident #1 ' s side of her head was pressed against the nightstand with blood drainage noted. Her left lower leg was observed with skin tears. Nurse #2 indicated Resident #1 was alert and oriented and complained of back and head pain. Under the possible causative factors section of the form, Nurse #2 indicated bed remote in way. An SBAR (Situation Background Assessment Recommendation) change in condition electronic note dated 9/2/20 (was there a time) indicated Resident #1 had a witnessed fall from bed resulting in a laceration to left side of head and skin tears to left lower extremity. Resident #1 ' s left side of head was leaning on nightstand and blood was noted under the head on a blanket between the resident ' s head and the nightstand. During a pain assessment Resident #1 indicated an aching back and throbbing head pain at a rating of 8 on a scale of 1 to 10. The Nurse Practitioner (NP) was notified, and the resident was sent to the Emergency Department (ED) for evaluation and treatment. ED documentation dated 9/2/20 indicated Resident #1 rolled off bed while being cleaned up by staff, she hit her head on a dresser, and sustained wounds to her left leg. The physical exam showed a 2 centimeter (cm) linear scalp laceration to the head with minimal gaping as well as superficial scattered skin tears to lower extremity, and a large skin tear to the left lateral leg adjacent to the left knee approximately 8 cm x 8 cm. 2 staples were placed to Resident #1 ' s scalp laceration and her skin tears were cleansed, treated with antibiotic ointment, and dressed. The ED physician indicated that given the multiple scattered skin tears, Keflex (antibiotic medication) was ordered for outpatient therapy to prevent the development of bacterial infections. A nursing note dated 9/2/20 at 7:42 PM written by Nurse #1 indicated Resident #1 arrived back from hospital via Emergency Medical Services (EMS). She had 2 staples to the left upper

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) forehead with some bleeding and skin tears to upper and lower outer leg. A review of the facility Nurse Aide Activity of Daily Living assistance documentation for Resident #1 from her most recent readmission on 8/13/20 to 9/2/20 revealed the following: - Bed Mobility: 3 total documented, 1 documented as dependent with 2+ assist (8/15/20 1st shift, 9/1/20 2nd shift), and 1 documented as dependent with 1 assist (9/2/20 2nd shift) The NA Care Guide, a guide that describes the resident ' s care needs, undated, indicated Resident #1 was incontinent of bowel and required 2 person assist with incontinence care, required total assistance of 2 staff members with mechanical lift for transfers, and required hands on assistance of one staff member to turn and reposition in bed. An interview was conducted with NA #1 on 9/29/20 at 1:00 PM. NA #1 reported she was familiar with Resident #1 and was working with her at the time of her 9/2/20 fall from bed that occurred during care. She indicated that Resident #1 required assistance with ADLs and that when she became sick from COVID (confirmed positive 7/30/20) she needed additional assistance as she was weaker. She stated that once on the COVID unit Resident #1 required the assistance of 2 staff for a bed bath due to the increased weakness as well as her physical size, and it was too much for 1 person to do on their own safely. NA #1 indicated that Resident #1 was on the COVID unit on 9/2/20 and she and Nurse #2 were the only staff members working on the COVID unit as there were about 10 residents total on the unit. She stated that on 9/2/20 she needed to give Resident #1 a bed bath which required 2 staff members for assistance. NA #1 revealed that at the time of the bed bath, Nurse #2 was completing her medication pass and she had not wanted to interrupt her, so she gave the bed bath to Resident #1 without anyone else ' s assistance. She explained that once staff entered the COVID unit, they were not able to re-enter any other areas of the facility. She further explained that this was why she was unable to ask a staff member who was not assigned to the COVID unit for help. NA #1 indicated that when she was finishing up Resident #1 ' s bed bath on 9/2/20, she rolled Resident #1 onto her side, away from the center of the bed, in order to change her linens. She reported that she was then positioned on the opposite side of the bed as the resident. She stated that Resident #1 must have accidentally hit the bed remote which tilted the head of the bed up and subsequently caused her to roll off the bed and onto the floor. NA #1 stated that she was unable to stop Resident #1 from rolling as she was on the opposite side of the bed. She indicated that Resident #1 hit her head on her nightstand and had several cuts on her leg. She stated that she immediately called for help and Nurse #1 came to assist her. NA #1 revealed that she should have waited for assistance from Nurse #2 to provide the bed bath. She explained that if Nurse #2 was with her, that she would have been positioned on the side of the bed the resident had rolled off of and could have prevented the fall. NA #1 was asked how she knew how much assistance Resident #1 required. She stated that she was familiar with the resident and that she talked to the other NAs who worked with her. An interview was conducted with NA #2 on 9/29/20 at 3:35 PM. She indicated that she was familiar with Resident #1 and that she required a 2 person assist for bed baths. She explained that this level of assistance was needed because of physical limitations and physical size. An interview was conducted with Nurse #1 on 9/29/20 at 3:40 PM. Nurse #1 indicated she was familiar with Resident #1. She reported that once Resident #1 was diagnosed with [REDACTED]. Nurse #1 explained this was because of physical limitations and physical size. A phone interview was conducted with Nurse #2 on 9/30/20 at 3:20 PM. She reported that she was familiar with Resident #1 and that she was working on the COVID unit at the time of her 9/2/20 fall from bed that occurred during care. She stated that on 9/2/20 she was in another resident ' s room when she heard NA #1 calling for help. She indicated that she stopped what she was doing and went into Resident #1 ' s room to assist NA #1. She stated she observed Resident #1 lying on the floor on the left side between the bed and the nightstand with her head against the nightstand. She reported that when she assessed the resident she had a laceration to the head, skin tears to her left leg, and the resident self-reported pain in her neck, back, and head. She stated that she wanted to transfer the resident from the floor to the bed, but was unable to secure a mechanical lift pad under the resident without additional staff assisting. She explained that she and NA #1 were not able to complete this task without help due to Resident #1 ' s bodyweight and her physical inability to bear weight at that time so the resident remained on the floor and EMS was called. Nurse #2 reiterated NA #1 ' s interview that once a staff member entered the COVID unit that they were unable to return to their previous assignment off of the COVID unit. She stated that she asked NA #1 what happened, and she said that she rolled Resident #1 onto her side and the resident must have either pressed the head tilt button on the remote or rolled on top of it, causing the head of the bed to raise up, and subsequently caused the resident to start rolling and she rolled right off the bed. Nurse #2 indicated that she was not sure what level of assistance Resident #1 normally required for bed baths, but that if NA #1 had asked her for help that she would have assisted when she was able. An interview was conducted with the DON on 9/29/20 at 1:40 PM. She stated that she began working at the facility in the beginning of August 2020. She indicated that she was familiar with Resident #1 and she completed an investigation into the 9/2/20 fall that occurred during care. The DON stated that she interviewed NA #1 and Nurse #2 in detail about the fall. During these interviews she determined that most often Resident #1 required 2+ assistance with ADL tasks of bed mobility, incontinent care, and bed baths. She stated that her investigation identified a twofold root cause for Resident #1 ' s 9/2/20 fall. The DON explained that 2 staff should have been used for Resident #1 ' s bed bath due to her care needs and that staff needed to ensure the bed control was positioned off of the bed to avoid any accidental pressing of the control. She reported that she began a PIP (Performance Improvement Plan) related to the 9/2/20 fall for Resident #1, but the plan had not been fully implemented as of 9/29/20. On 9/29/20 at 3:10 PM the DON provided a copy of the PIP and education inservices completed as of 9/29/20. A review of these documents revealed the PIP had not been fully implemented and education had not been completed.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and Pharmacy Consultant interview, the facility failed to act upon recommendations made by the Pharmacy Consultant for 1 of 3 residents (Resident #3) reviewed for unnecessary medications. The findings included: Resident #3 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #3 on 12/22/19. She was assessed with [REDACTED].#3 indicated Quetiapine [MEDICATION NAME] (antipsychotic medication) 25 milligrams (mg) twice daily for delusions. A physician's order [REDACTED].#3 ' s Quetiapine [MEDICATION NAME] and initiated [MEDICATION NAME] (antipsychotic medication) 7.5 mg in the evening for [MEDICAL CONDITION]. A Pharmacy Consultation Report dated 8/13/20 indicated Resident #3 received [MEDICATION NAME] which could cause involuntary movements, but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condenser User Scale (DISCUS) assessment was not documented in the medical record within the previous 6 months. The Pharmacy Consultant recommended the completion of one of these monitoring assessments (AIMS or DISCUS) now and at least every 6 months thereafter or per facility protocol as early detection of involuntary movements could prevent potentially irreversible side effects. This Pharmacy Consultant ' s recommendation was addressed to the facility ' s former Director of Nursing (DON). The form required a signature from the former DON, and the signature line was blank. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 ' s cognition was intact, and she received antipsychotic medication on 7 of 7 days. A review of Resident #3 ' s active physician's order [REDACTED]. A review of Resident #3 ' s medical record on 9/30/20 revealed no AIMS assessment, or any other involuntary movement assessment had been completed for Resident #3 since 12/22/19. During a phone interview with the Pharmacy Consultant on 10/1/20 at 10:11 AM she reported that she expected an AIMS assessment to be completed on admission for residents admitted on antipsychotic medication, on initiation of antipsychotic medication if the resident was started on the antipsychotic while at the facility, and then every 6 months thereafter as long as the antipsychotic medication was in use. She explained that routine AIMS assessments for residents on antipsychotic medication were necessary due to the potential irreversible side effects of antipsychotic medications. The 8/13/20 pharmacy recommendation for an AIMS assessment to be completed for Resident #3 was reviewed with the Pharmacy Consultant. She stated she was not sure if the facility had acted upon her recommendation. She indicated she needed to review her records. On 10/1/20 at 11:02 AM the Director of Nursing (DON) requested a three way conference call interview be conducted with herself and the Pharmacy Consultant. The Pharmacy Consultant and the DON revealed the 8/13/20 pharmacy recommendation for the completion of an AIMS assessment for Resident #3 had not been acted upon by the facility. The DON explained that she began working at the facility in the beginning of August 2020 and the former DON ceased working at the facility. The Pharmacy Consultant stated that she was not aware of the DON transition, so she sent the August 2020 monthly drug regimen reviews (DRRs) and recommendations to the former DON by electronic mail. The Pharmacy Consultant and DON both indicated that they were unaware

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) until today (10/1/20) that the August 2020 DRRs and recommendations had not been reviewed and/or acted upon. The Pharmacy Consultant explained that her September 2020 DRRs were completed on 9/3/20 and she typically gave 30 days before making a repeat recommendation, so she would have made repeat recommendations from the August 2020 DRRs (completed 8/13/20) during her October 2020 DRRs. The DON reported she expected pharmacy recommendations to be reviewed and separated into recommendations for nursing and recommendations for the physician on the date of their receipt from the Pharmacy Consultant. She indicated that she expected the nursing recommendations to then be reviewed and acted upon within the next day or two. The DON further indicated that this expectation was not met as Resident #3 ' s 8/13/20 pharmacy recommendation for the completion of an AIMS assessment was not acted upon.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident, staff, and Pharmacy Consultant, the facility failed to assess a resident on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder, for 1 of 3 residents (Resident #3) reviewed for unnecessary medications. The findings included: Resident #3 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #3 on 12/22/19. She was assessed with [REDACTED].#3 indicated Quetiapine [MEDICATION NAME] (antipsychotic medication) 25 milligrams (mg) twice daily for delusions. A physician's order [REDACTED].#3 ' s Quetiapine [MEDICATION NAME] and initiated [MEDICATION NAME] (antipsychotic medication) 7.5 mg in the evening for [MEDICAL CONDITION]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #3 received antipsychotic medication on 7 of 7 days. Resident #3 ' s care plan, last reviewed on 9/18/20, included a focus area related to the use of antipsychotic medication. The interventions included, in part, administering the antipsychotic medication as ordered and monitoring for behavioral symptoms. A review of Resident #3 ' s active physician's order [REDACTED]. A review of the physician's order [REDACTED]. A review of the medical record revealed no AIMS assessment, or any other involuntary movement assessment had been completed for Resident #3 since 12/22/19. An interview and observation were conducted with Resident #3 on 9/29/20 at 12:15 PM. Resident #3 was alert and oriented and reported no concerns with her medications or medication side effects. She was observed with no abnormal involuntary movements. A phone interview was conducted with the Director of Nursing (DON) on 10/1/20 at 9:55 AM. She stated that she began working at the facility in early August 2020. She reported that the facility ' s normal protocol was for AIMS assessments to be completed on admission for residents on antipsychotic medication, on initiation of an antipsychotic medication, and then every 6 months. The DON indicated that the AIMS assessments were located in the Electronic Medical Record (EMR). She stated the EMR automatically populated the AIMS assessment for the nurse to complete when it was due. She reported that the nurse who was working at the time the assessment populated in the EMR was responsible for its completion. Resident #3 ' s last AIMS assessment dated [DATE] was reviewed with the DON. The DON confirmed this was the most recent AIMS assessment completed for Resident #3. She revealed she had not known why the EMR had not automatically populated the AIMS assessment for the nurse to complete. She indicated that an AIMS assessment needed to be completed for Resident #3 as it was never completed when antipsychotic medication was initiated (7/16/20). During a phone interview with the Pharmacy Consultant on 10/1/20 at 10:11 AM she reported that antipsychotic medications could cause involuntary movement disorders. She indicated this was why it was pertinent to complete an AIMS assessment or other assessment of involuntary movement on admission for residents admitted on antipsychotic medication, on initiation of antipsychotic medication if the resident was started on the antipsychotic while at the facility, and then every 6 months thereafter as long as the antipsychotic medication was in use. She explained that routine AIMS assessments for residents taking antipsychotic medication were necessary due to the potential irreversible side effects of the medications.