STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tower Nursing and Rehabilitation Center	3609 Bond Street Raleigh, NC 27604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of Pre-Admission Screening and Resident Review (PASRR) for 2 of 19 sampled residents whose MDS were reviewed (Resident #56 and Resident #23). The findings included: 1. Resident #56 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder and anxiety. Review of the Pre-Admission Screening and Resident Review (PASRR) Level II Determination Notification dated 3/14/23 revealed Resident #56 was appropriate for nursing home placement. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #56 was not coded to reflect his PASRR Level II status. An interview was conducted with the MDS Nurse on 2/07/24 at 10:40 am who confirmed Resident #56 had a PASRR Level II. The MDS Nurse stated she was not sure how she missed the PASRR Level II information for Resident #56 when she completed his annual assessment. An interview was conducted on 2/07/24 at 2:38 pm with the Administrator who revealed the MDS Nurse was responsible to ensure Resident #56's MDS assessments were coded correctly. 2. Review of the Pre-Admission Screening and Resident Review (PASRR) Level II Determination Notification dated 9/13/21 revealed Resident #23 was appropriate for nursing home placement. Resident #23 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder and personality/behavioral disorder. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #23 was not coded to reflect his PASRR Level II status. During an interview on 2/07/24 at 2:06 pm the MDS Nurse revealed Resident #23's electronic medical record was not updated with the PASRR Level II information at the time the MDS assessment was completed. The MDS Nurse stated whoever received the PASRR Level II Determination Notification was responsible to update the electronic medical record with the information. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/07/24 at 2:13 pm with the Admission Director who revealed she was responsible to ensure Resident #23's PASRR Level II status was updated in the electronic medical record when he was admitted to the facility. She stated she must have seen the PASRR Level I information on the medical record from a previous admission and just assumed it was the correct information. The Admission Director stated she completed an audit at a later date and realized she did not have the correct PASRR information listed for Resident #23, so she updated the medical record with the PASRR Level II information. An interview with the Administrator was conducted on 2/07/24 at 2:38 pm. The Administrator stated the PASRR Level II information for Resident #23 should have been updated by the Admission Director, so the information was available so the MDS Nurse could accurately complete the assessment.

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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** 45045 Based on observations, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to develop a person-centered care plan for 1 of 1residents reviewed for activities (Resident #5). The findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses which included stroke and major depressive disorder. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #5 had moderately impaired cognition. Resident #5 reported the following activity preferences were very important: books, magazines, and newspapers to read, listen to music, participate in group activities, participate in religious services, and to be outdoors for fresh air when weather was good. Resident #5's care plan initiated on 10/16/23 and last updated on 2/05/24 revealed she had a care plan in place for daily preferences and activity preferences related to daily care. A care plan goal was in place for Resident #5's daily and activity preferences to be provided through the next review. The care plan had no interventions noted at the time of initial review on 2/05/24. An observation on 2/05/24 at 10:05 am revealed Resident #5 was alone in her room, sitting in her wheelchair with a single coloring sheet and colored pencils. A telephone interview was conducted on 2/05/24 at 11:47 am with Resident #5's Responsible Party (RP) who revealed she had discussed with the facility during an interview the activities that Resident #5 enjoyed which included music, coloring, attending church services, and group activities. Resident #5's RP stated when she visited Resident #5, she was most often alone in her room with coloring sheets. An interview was conducted on 2/06/24 at 1:11 pm with the Activity Assistant who revealed the MDS Nurse was responsible to create Resident #5's care plan because she was not able to create care plans. The Activity Assistant stated Resident #5 did participate in group activities for church services and movies at times, but often she delivered coloring pages to her room because she knows Resident #5 enjoyed coloring. An interview was conducted on 2/07/24 at 12:09 pm with Nurse Aide (NA) #1 who revealed he provided care to Resident #5 during the 7:00 am-3:00 pm shift. NA #1 stated he was unsure of what activities Resident #5 enjoyed participating in, but he stated if he knew he would take her to the scheduled activity of her choice. An interview was conducted on 2/07/24 at 1:35 pm with Nurse #2 who he did not know if there was an activity that he could offer for Resident #5 when she was in her room alone. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/07/24 at 1:54 pm with the MDS Nurse she revealed she was responsible for completing the care plan for Resident #5, but she was unable to state why there were no interventions for the activity care plan. The MDS Nurse stated she noticed there were no interventions listed for Resident #5's activity care plan, so she added color with color pencils and coloring pages on 2/05/24. The MDS Nurse stated she did not review the MDS admission assessment for the activity preferences to create a person-centered care plan for Resident #5, but stated she recalled Resident #5 enjoyed coloring in the past. An interview was conducted with the Administrator on 2/07/24 at 2:47 pm who revealed the MDS Nurse was responsible for Resident #5's activity care plan. The Administrator stated Resident #5's care plan interventions should have been added when the care plan was created.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35122 Based on observation, record review and staff interviews, the facility failed to maintain an accurate count of a controlled antianxiety medication for 1 of 4 residents observed for controlled substance administration (Resident #56). Findings included: Review of Resident #56's February 2024 Medication Administration Record (MAR) revealed he received alprazolam 1 milligram (mg) at 8:00 AM, 12:00 PM and 4:00 PM daily. A medication administration observation was conducted on 2/07/24 at 8:20 AM with Nurse #2. The nurse verified Resident #56's medications, opened the locked narcotic box and retrieved Resident #56's alprazolam 1 mg tablets. The individual tablets were in a blister pack with each tablet numbered. Upon removal from the box, the blister pack showed there were 19 tablets. Nurse #1 removed one tablet and showed there were 18 tablets remaining in the blister pack. At the time of the observation a review of Resident #56's Controlled Substance Count Record for alprazolam 1 mg was completed with Nurse #2. There was a line for each tablet's administration documentation which included the quantity, date, time, amount given, amount left, and a space for the nurse's signature. The previous notation indicated there had been 20 tablets remaining in the blister pack. Nurse #2 was observed writing on the next line of the Controlled Substance Count Record that there had been quantity 19 tablets, and the amount left was 18 tablets. The Shift-Change Controlled Substance Count Check form was noted as signed as completed on 2/06/24 at 7:00 PM and again on 2/07/24 at 7:00 AM, both counts had been conducted by Nurse #2 and Nurse #3. On 2/07/24 at 8:21 AM Nurse #2 was asked about the Controlled Substance Count Record discrepancy indicating there were 20 tablets remaining on the previous line, and after removing 1 tablet there were now 18 left. He explained when he and Nurse #3 counted the controlled substances on 2/06/24 at 7:00 PM and again on 2/07/24 at 7:00 AM the count was correct. He then took the blister pack and the Controlled Substance Count Record to the Director of Nursing (DON). A phone interview with Nurse #3 was conducted on 2/07/24 at 7:17 PM. Nurse #3 stated she had counted the controlled medications twice with Nurse #2 when she was starting her shift on 2/06/24 at 7:00 PM and again on 2/07/24 when she was ending her shift. She explained they looked at both the blister pack card and the Controlled Substance Count Record for each medication to make sure the numbers were correct. She explained she could only think that she did not pay close attention and thought the count had been correct. Nurse #3 stated she could not explain how that medication had been miscounted twice. On 2/07/24 at 8:30 AM the DON reviewed the Controlled Substance Count Record and Resident #56's MAR. She noted the 2/06/24 at 4:00 PM scheduled dose had been signed on the MAR by Nurse #2 but not the Controlled Substance Count Record. She stated she was unsure how the controlled medications could have been counted twice as correct when they were not. (continued on next page)

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	345513	A. Building B. Wing	02/08/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/07/24 at 2:38 PM the DON stated it was their process for the on-coming and off-going nurses to count both the controlled substance blister pack cards and sign-off sheets to make sure the numbers match with both nurses looking at and verifying the medications as correct. She explained she would expect controlled substances to be signed out when they were administered.

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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** 45045 Based on record review, staff interviews, Consultant Pharmacist interview, and Medical Director interview, the facility failed to address recommendations made by the Consultant Pharmacist based on the monthly Medication Regimen Review (MRR) for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The findings included: The hospital discharge summary dated 10/05/23 revealed Resident #5 was discharged with an order for trazodone (an antidepressant medication) 50 milligram (mg) tablet take 0.5 tablet (25 mg) by mouth nightly for 30 days. Resident #5 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder and anxiety. An active physician order entered by Nurse #1 and dated 10/06/23 for trazodone oral tablet 50 mg. Give 1/2 tablet by mouth one time a day for depression; give 25 mg by mouth nightly for depression. The physician order did not have a stop date. A telephone interview was conducted on 2/07/24 at 10:24 am with Nurse #1 who revealed she did not recall entering the trazodone order for Resident #5, but she thought all medication orders were checked by nursing management after admission and would have expected the error to be corrected if needed. Nurse #1was unable to state why the trazodone order was not transcribed correctly for Resident #5. Record review of Resident #5's Consultant Pharmacist's Medication Regimen Review (MMR) dated 10/24/23 revealed the Consultant Pharmacist reported the trazodone was transcribed incorrectly without a stop date. Please correct/clarify. Record review of Resident #5's electronic medication administration records (MAR) revealed Resident #5 received the trazodone medication nightly from 10/06/23 through 2/06/24. An interview was conducted on 2/07/24 at 11:43 am with the Director of Nursing (DON) who revealed the previous Unit Manager was responsible for the Consultant Pharmacist recommendations for Resident #5 to be reviewed and addressed as needed. The DON stated she did not request the MMRs to be returned to her when completed, and she did not check with the previous Unit Manager to ensure the Consultant Pharmacist MMR was addressed. The DON stated she was not aware that the MMR was not addressed prior to this date. The DON stated new admission medication reviews were completed in the morning clinical meeting but that did not include matching the hospital discharge orders to the entered orders for accuracy in transcription. The DON was unable to state how the Consultant Pharmacist recommendation for Resident #5's trazodone was missed for so long. The previous Unit Manager was unavailable for a telephone interview on 2/07/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 2/08/24 at 9:02 am with the Medical Director who revealed she normally reviewed the hospital discharge orders when she confirmed and signed the orders entered by the facility, but she was unable to state how she missed the trazodone order discrepancy from the discharge summary. The Medical Director stated she was not concerned that Resident #5 continued with the trazodone medication, but she stated she did not receive the Consultant Pharmacist recommendation from the facility to review for Resident #5's trazodone medication. An interview was conducted with the Administrator on 2/07/24 at 2:42 pm who confirmed she received an email from the Consultant Pharmacist regarding the Medication Regimen Reviews for the facility, but she stated the DON was responsible for the Consultant Pharmacist recommendations. The Administrator was unable to state how the MMR for Resident #5's trazodone order was missed. A telephone interview was conducted on 2/08/24 at 9:09 am with the Consultant Pharmacist who revealed the normal process for the Medication Regimen Review was to send the report via email to the DON and the Administrator of the facility as well as to send a copy in the pharmacy delivery tote to be reviewed and addressed as needed. The Consultant Pharmacist stated they would try to review the previous MMR during the next visit to see if recommendations were acted upon by the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45045 Based on record review, staff interviews, and Medical Director interview, the facility failed to stop an antidepressant medication prescribed for 30 days which resulted in the resident receiving the medication over the prescribed 30 days for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The findings included: Resident #5's hospital discharge summary dated 10/05/23 revealed an order for trazodone (an antidepressant medication) 50 milligram (mg) tablet take 0.5 tablet (25 mg) by mouth nightly for 30 days. Resident #5 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, anxiety, and schizoaffective disorder. An active physician order dated 10/06/23 for olanzapine (an antipsychotic medication) 5 mg tablet, give 4 tablets at bedtime for schizoaffective disorder. An active physician order dated 10/06/23 for escitalopram (an antidepressant medication) 5 mg daily for depression. An active physician order dated 10/06/23 for trazodone oral tablet 50 mg. Give 1/2 tablet by mouth one time a day for depression; give 25 mg by mouth nightly for depression. The physician order did not have a stop date. A telephone interview was conducted on 2/07/24 at 10:24 am with Nurse #1 who entered the trazodone order for Resident #5. Nurse #1 was unable to state why the trazodone order did not include the stop date from the hospital discharge summary for Resident #5. Record review of Resident #5's Consultant Pharmacist's Medication Regimen Review (MMR) dated 10/24/23 revealed the Consultant Pharmacist reported the trazodone was written incorrectly without a stop date. Please correct/clarify. Record review of Resident #5's Consultant Pharmacist's Recommendation dated 1/26/24 revealed a gradual dose reduction (GDR) was recommended for the trazodone order because Resident #5 had been using the medication since 10/06/23. The electronic medication administration records (MARs) were reviewed and revealed the trazodone 25 mg was administered to Resident #5 every night from 10/06/23 through 2/06/24. During an interview on 2/07/24 at 11:43 am with the Director of Nursing (DON), she revealed the new admission medications were reviewed in the morning clinical meeting but that did not include matching the hospital discharge orders to the entered orders for accuracy. The DON was unable to state how the stop date for Resident #5's trazodone was missed for so long. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The previous Unit Manager was unavailable for a telephone interview on 2/07/24. A telephone interview was conducted on 2/08/24 at 9:02 am with the Medical Director who revealed Resident #5 required the trazodone when she was admitted to the facility because the change of environment was a difficult adjustment and the trazodone helped to calm her. The Medical Director stated she reviewed the hospital discharge summary orders before she signed the facility orders to ensure they were entered accurately, but she stated she missed that the order did not have the stop date. The Medical Director stated she did not receive the Consultant Pharmacist recommendation from the facility regarding the incorrect transcription with no stop date for Resident #5's trazodone order. The Medical Director reported she completed a gradual dose reduction (GDR) recommendation from the Consultant Pharmacist Recommendation on 2/07/24 for Resident #5's trazodone.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review, observations, and staff interviews, the facility failed to refrigerate medications according to manufacturer's recommendations for 1 of 1 medication refrigerators located in the Medication room. Findings included: The manufacturer's recommendations for Insulin glargine, insulin degludec and Humulin R recommended that insulin be stored in a refrigerator at approximately 36 to 46 [degrees Fahrenheit] to avoid freezing. On 2/07/24 at 1:45 PM the Medication Room was observed with Nurse #4. The medication top-freezer refrigerator was observed with a secured lock on the refrigerator section. Inside the top-freezer was a white plastic basket containing: 1- Insulin glargine 10 milliliters (ml) multidose vial unopened 2- Insulin glargine 3 ml injection pens 2- Insulin deglu[DATE] ml injection pens 2- Insulin dulaglutide 0.5 ml injection pens 3- Humulin R 10 ml multidose vials unopened On 2/07/24 at 1:47 PM Nurse #4 stated the insulins should not have been placed into the freezer. Nurse #4 explained the refrigerator was kept locked due to controlled substances which required refrigeration. She further explained the hall nurses each had a key to the Medication Room but only the 100-Hall nurse had the key to the medication refrigerator. On 2/07/24 at 2:38 PM an interview with the Director of Nursing (DON) was conducted. She stated she stated she was unsure who would place insulin into the freezer and not the refrigerator. She explained insulin should not be frozen and would expect the nurses to store the insulin as directed. On 2/08/24 at 8:57 AM an interview with the Administrator was conducted. She stated insulin should be stored at the proper temperature.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45045 Based on observations, record review, staff interviews, and Medical Director interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 8/27/21 recertification and complaint investigation survey and the 10/15/22 recertification and complaint investigation survey. This was for 5 recited deficiencies on the current recertification and complaint investigation survey of 2/08/24 in the areas of Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plan (F656), Pharmacy Services/Procedures/Pharmacist/Records (F755), Free from Unnecessary Psychotropic Medications (F758), and Label/Store Drugs & Biologics (F761). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of Pre-Admission Screening and Resident Review (PASRR) for 2 of 19 sampled residents whose MDS were reviewed (Resident #56 and Resident #23). During the 8/27/21 recertification and complaint investigation survey the facility failed to accurately code the Minimum Data Set (MDS) assessment. During the 10/15/22 recertification and complaint investigation survey the facility failed to accurately code the smoking status of a resident on a Minimum Data Set (MDS) assessment. An interview was conducted on 2/08/24 at 10:30 am with the Administrator who revealed the facility monitored each section of the MDS assessments for accuracy, but the PASRR information was a slight oversight on the part of the facility. F656: Based on observations, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to develop a person-centered care plan for 1 of 1residents reviewed for activities (Resident #5). During the 10/15/22 recertification and complaint investigation survey the facility failed to develop and implement an individualized person-center care plan. An interview was conducted on 2/08/24 at 10:30 am with the Administrator who revealed the care plans were reviewed and updated by the interdisciplinary team (IDT). The Administrator was unable to state how the care plan was missed. F755: Based on observation, record review and staff interviews, the facility failed to maintain an accurate count of a controlled antianxiety medication for 1 of 4 residents observed for controlled substance administration (Resident #56). (continued on next page)

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	345513	A. Building B. Wing	02/08/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the 10/15/22 recertification and complaint investigation survey the facility failed to establish a secured and effective system to contain and record control drugs to be returned to the pharmacy for a discharge resident. During an interview on 2/08/24 at 10:30 am the Administrator stated the facility had completed audits of the medication carts, but she was unable to state how the oversight occurred. F758: Based on record review, staff interviews, and Medical Director interview, the facility failed to stop an antidepressant medication prescribed for 30 days which resulted in the resident receiving the medication over the prescribed 30 days for 1 of 5 residents reviewed for unnecessary medications (Resident #5). During the 8/27/21 recertification and complaint investigation survey the facility failed to obtain a stop date for an as needed (prn) antipsychotic medication. During the 10/15/22 recertification and complaint investigation survey the facility failed to implement a 14-day stop date for an as needed psychotropic medication. An interview was conducted with the Administrator on 2/08/24 at 10:30 am who revealed the normal process was for the IDT team to discuss and review all orders and pharmacy recommendations. The IDT team had completed audits to ensure the identified areas were completed but this was somehow missed during their review. F761: Based on record review, observations, and staff interviews, the facility failed to refrigerate medications according to manufacturer's recommendations for 1 of 1 medication refrigerators located in the Medication room. During the 8/27/21 recertification and complaint investigation survey the facility failed to label an open vial of insulin on one of three medication carts reviewed, and the facility failed to affix the locked narcotic box to the refrigerator in one of one medication rooms reviewed. During the 10/15/22 recertification and complaint investigation survey the facility failed to date two opened medications for 1 of 2 medication carts used for medication administration and failed to store medication in a locked cabinet. An interview was conducted on 2/08/24 at 10:30 am with the Administrator who revealed the facility had diligently checked medication rooms and carts daily and she was unable to state how the oversight occurred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tower Nursing and Rehabilitation Center	3609 Bond Street Raleigh, NC 27604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on record review and staff interviews, the facility failed to administer the pneumococcal vaccine to eligible residents for 2 of 5 residents reviewed for immunizations (Resident #65 and Resident #69). The findings included: The facility policy for Immunizations last revised on 10/2/20 read in part Pneumococcal Immunization: Residents will be offered the immunization upon admission, unless it is medically contraindicated or the resident has already been immunized, and the resident or the resident's representative refuses after receiving appropriate education and consultation regarding the benefits of pneumococcal immunization. Upon consent, the pneumococcal vaccine will be given according to the Centers for Disease Control and Prevention and Advisory Committee for Immunization Practice recommendations. a. Resident #65 was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #65 was not up to date with the pneumococcal vaccine and that it was offered and declined. Review of Resident #65's admission packet revealed Resident #65 gave authorization for the pneumococcal vaccine to be administered. Review of Resident #65's immunization record on 2/6/24 revealed no documentation that the pneumococcal vaccine was administered. Review of a health status note dated 2/6/24 revealed that Resident #65 was offered the pneumococcal vaccine, and he declined. An interview was conducted with the Infection Preventionist/Director of Nursing on 2/07/24 at 1:14 PM. She stated that the policy states that the pneumococcal immunization should be offered upon admission if it was not previously received. The Admissions Director reviewed consent for immunizations during the admission process, and the interdisciplinary team (IDT) meeting should follow-up on the resident's response. The floor nurse or unit manager were responsible to administer the vaccine. The Infection Preventionist/Director of Nursing stated that the information for Resident #65 should have been forwarded to the IDT to ensure the vaccines were administered. During an interview with the Administrator on 2/7/24 at 11:10 AM, she revealed that Resident #65 accepted the pneumococcal vaccine when completing the consent/release form within the admissions packet. She stated that she was uncertain what happened after he was admitted , but if he accepted the vaccine then it should have been administered. b. Resident #69 was admitted to the facility on [DATE] with a diagnosis of diabetes. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #69 was not up to date with the pneumococcal vaccine and that it was not offered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tower Nursing and Rehabilitation Center	3609 Bond Street Raleigh, NC 27604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's admission packet revealed Resident #69 gave authorization for the pneumococcal vaccine to be administered. Review of Resident #69's immunization record on 2/6/24 revealed no documentation that the pneumococcal vaccine was administered. An interview was conducted with the Infection Preventionist/Director of Nursing on 2/07/24 at 1:14 PM. She stated that the policy states that the pneumococcal immunization should be offered upon admission if it was not previously received. The Admissions Director reviewed consent for immunizations during the admission process, and the interdisciplinary team (IDT) meeting should follow-up on the resident's response. The floor nurse or unit manager were responsible to administer the vaccine. The Infection Preventionist/Director of Nursing stated that the information for Resident #69 should have been forwarded to the IDT to ensure the vaccines were administered. During an interview with the Administrator on 2/07/24 at 11:07 AM, she revealed that the admitting nurse and Admissions Director offer consent for the pneumococcal vaccine. The Administrator stated she why Resident #69 did not receive the vaccine after he had consented. If Resident #69 consented to the pneumococcal vaccine upon admission, then the vaccine should have been provided.