STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH REHABILITATION CENTER	**616 WADE AVENUE RALEIGH, NC 27605**

(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) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification Survey was conducted from 7/12/21 to 7/16/21. The facility was found in compliance with the regulation CFR 483.73, Emergency Preparedness. Event ID: 5AOI11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted on 7/12/21 through 7/16/21. Event ID: 5AOI11. 2 of the 7 complaint allegations were substantiated resulting in deficiencies. A Recertification/Complaint Survey was conducted from 7/12/21 to 7/16/21. Past-noncompliance was identified at CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted substandard quality of care. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		8/4/21

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

Electronically Signed | 08/04/2021

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to honor the dignity of 2 of 2 residents reviewed when a Nurse Assistance (NA) instructed a resident (Resident #11) to stop ringing her call bell and when staff failed to provide incontinence care to a resident (Resident #41) during mealtimes. Findings included:	F 550	F550-Dignity 1-An interview was conducted with Resident #11 on 7/16/21 by the DON. Resident #11 did not voice any concerns. An interview was conducted with Resident #41 on 7/16/21 by the DON. Resident #41 did not voice any concerns. NA #2 received re-education by DON/UM on	

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F 550	Continued From page 2 1.Resident #11 was admitted to the facility on 6/10/17 with diagnosis that included stroke, hypertension and hemiplegia. A review of the quarterly Minimum Data Set (MDS) assessment dated 4/15/21 revealed Resident #11 was cognitively intact. The resident was assessed to require extensive assist with 1-person physical assistance for bed mobility, dressing and personal hygiene and total assist with 2-person physical assistance for transfer. An observation on 7/12/21 at 12:08PM revealed NA #2 answered the call bell for Resident #11. NA #2 was heard to tell the resident to quit pushing the call light. When Resident #11 asked why, NA #2 stated she had been in the room multiple times today. During an interview on 7/12/21 at 12:10PM, NA #2 stated she was familiar with Resident #11 and often jokes with the resident. She further stated the resident pushed her call bell multiple times and often did not have care needs. NA #2 stated she had provided care to the resident, which included getting the resident in her wheelchair. During an interview with Resident #11 on 7/12/21 at 12:12PM, she stated there were times when she pushed her call bell and staff told her to quit pushing the call bell. During a subsequent interview with Resident #11 on 7/14/21 at 2:30PM, she revealed she was unable to get the assistance she needed when staff quit answering her call bell. An interview with NA #3 on 7/13/21 at 9:01AM revealed Resident #11 pushed her call bell	F 550	7/16/21 regarding the importance of answering call lights. 2-Residents who require assistance with toileting have the potential to be affected. An audit was conducted on 7/16/21 on all alert and oriented residents who require assistance with toileting by facility management. At that time the residents were informed they can receive toileting assistance during mealtime if needed. Nursing and CNA staff were in-serviced starting 7/16/21 regarding the importance of answering call lights and providing toileting assistance to residents during meal time if needed or if requested. The expectation of providing toileting assistance during meal time has been added to the orientation process for nurses and CNAs. 3-Alert and oriented residents will be audited by the facility management team daily Monday through Friday regarding call light response. Toileting during meal time audits will be conducted with alert and oriented residents by the facility management team daily Monday through Friday. Along with the interviewable residents, dependent, non-verbal residents will be checked per weekly during meals to ensure residents are not eating while soiled. Random audits will be conducted for call lights and incontinence during mealtime by the Manager on Duty weekends. The audits will be conducted for 6 weeks, then monthly for 3 months.	

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F 550	Continued From page 3 frequently. NA #3 stated staff asked the resident if there was anything she needed before exiting the room. She further stated the resident would push the call bell immediately after the NA exited the resident's room. During an interview with NA #4 on 7/15/21 at 2:49PM, she stated there had been times where staff told residents to stop pushing call bells. An interview with Nurse #5 on 7/15/21 at 2:34PM revealed the NA was to answer resident call bells. He stated he was not aware of a time when a NA told a resident not to push their call bell, however, if he heard this, he would provide education regarding the resident's right to push the call bell. Nurse #5 stated Resident #11 pushed her call bell frequently and part of the interventions was to get the resident up. An interview was conducted with the Unit Manager #1 on 7/15/21 at 2:35PM. The Unit Manager #1 stated call bells were to be answered at all times. She further stated education would be provided to staff if they told a resident not to push a call bell. 2. Resident #41 was admitted to the facility on 5/29/21 with diagnoses that included muscle weakness, hyperlipidemia and anemia. A review of the admission Minimum Data Set (MDS) assessment dated 6/4/21 revealed Resident #41 was cognitively intact. The assessment indicated the resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident was assessed as needing extensive assist with 2-person physical assistance for toilet use.	F 550	4-Results of the audits will be reviewed during QA & A Committee monthly for 3 months. Recommendations will be made based on outcomes of the audits. The committee will determine the need for further auditing beyond 3 months.	

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F 550	Continued From page 4	F 550		

During an interview with Resident #41 on 7/12/21 at 12:33PM, she indicated there were times when she became incontinent after the meal trays were on the hall. She further stated when she pushed her call bell, staff would not provide incontinence care until the meal trays were removed from the hall, so she had to remain in a soiled depends during the meal. Resident #41 stated this had upset her and she was physically uncomfortable. The resident further stated she was unaware of when she had a bowel movement until after she was done.

During an interview with the Occupational Therapist (OT) on 7/14/21 at 1:11PM, it was revealed Resident #41 was unaware when she was having a bowel movement until after it had occurred. The OT stated she was working with the resident to implement a toileting schedule and would be sharing this with staff once a pattern was established.

An interview was conducted with NA #3 on 7/15/21 at 2:30PM. She stated incontinence care was not to be provided while meal trays were on the hall.

During an interview with NA #5 on 7/15/21 at 2:55PM, she stated incontinence care was not provided during mealtimes.

An interview with Nurse #5 on 7/15/21 at 2:34PM revealed incontinence care was not provided during meal tray pass to prevent cross contamination. He further stated once the trays were passed, the NA should provide incontinence care.

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F 550	Continued From page 5 An interview was conducted with the Unit Manager #1 on 7/15/21 at 2:35PM. She stated incontinence care should be provided during mealtimes. An interview with the Director of Nursing on 7/15/21 at 3:03PM revealed incontinence care was to be provided during mealtimes.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 2 of 3 sample residents (Resident #23 and Resident #39) who were observed to have medications at bedside. The findings included: 1. Resident #23 was admitted to the facility on 11/9/18 with re-entry from a hospital on 2/18/21. His cumulative diagnoses included end stage renal disease and pancreatic insufficiency. The resident ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/29/21. The MDS revealed Resident #23 had intact cognitive skills for daily decision making. He was assessed as being independent with transfers, locomotion on/off the unit, and eating.	F 554	F554- Self administration of medications 1) Identified affected residents: #23, #39 Resident #23 was assessed for Self-administration of medication by the IDT team. The resident was offered the opportunity to self-administer medications and declined. Nurse #3 was immediately re-educated on 7/14/21 regarding not leaving medications at the bedside. Resident #39 was assessed for Self-administration of medication by the IDT team. The resident was offered the opportunity to self-administer medications and declined. 2) Residents having the potential to be affected: On 7/27/2021, alert and oriented	8/4/21

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F 554	Continued From page 6 The resident required supervision for bed mobility, dressing, and toileting with extensive assistance needed for personal hygiene. Resident #23 ' s current care plan included the following area of focus, in part: --(The resident) is non-compliant with the treatment regimen at times and non-compliant with dialysis at times (Date Initiated: 12/4/18; Revised on: 12/7/20). The resident was not care planned for the self-administration of his medications. A review of Resident #23 ' s electronic medical record revealed no assessments were completed for the self-administration of his medications. The resident ' s current physician orders included the following medications scheduled for administration each morning as follows: --Multiple vitamin to be given as one tablet by mouth (scheduled for 8:00 AM daily); --500 mg ascorbic acid (Vitamin C) to be given as one tablet by mouth (scheduled for 8:00 AM daily); --300 mg gabapentin (a medication which may be used to treat neuropathic pain) to be given as one capsule by mouth (scheduled for 8:00 AM daily); --667 mg calcium acetate (a phosphate binder) to be given as two capsules by mouth with meals (scheduled for 8:30 AM daily); --36000 units Creon DR Particles (pancreatic enzymes) to be given as two capsules by mouth with meals (scheduled for 8:30 AM daily); --81 milligrams (mg) aspirin tablet to be given by mouth (scheduled for 10:00 AM daily); --1000 micrograms (mcg) Vitamin B12 tablet to be given as one tablet by mouth (scheduled for 10:00 AM daily);	F 554	residents were reviewed by the DON, Administrator, and Social Worker for appropriateness of medication self-administration. Residents deemed appropriate were interviewed for the desire to self-administrator medications. None of the identified residents were interested in medication self-administration. 3) Nurse education was completed on 8/2/2021 to include medications are not to be left at the bedside unless there is an order for self-administration. 4) During the admissions review in the morning clinical meeting, the Interdisciplinary team will discuss if any newly admitted residents are appropriate for self-administration of medications. If the new admission is deemed appropriate, the DON/Unit Manager/Designee will interview/assess resident for self- administration. Checking for medications left at the bedside was added to the facility management team daily Angel Rounding tool. Education was provided to the management team on 7/21/21. Audits will be completed monthly X 3 months by the DON/designee. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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--4 grams (g) cholestyramine packet (an antilipemic medication used to reduce the amount of fats in the blood) to be given by mouth as one packet mixed in 4-8 ounces of liquid (scheduled for 10:00 AM daily);
--20 mg esomeprazole Delayed Release (DR) capsule (a medication used to treat gastro-esophageal reflux disease) to be given as one capsule by mouth (scheduled for 10:00 AM daily);
--1000 units Vitamin D3 tablet to be given as one tablet by mouth (scheduled for 10:00 AM daily).
The physician orders did not include an order for the resident to self-administer any of his medications.

An observation was conducted on 7/13/21 at 8:30 AM as Resident #23 was sitting in a wheelchair in his room. A medicine cup containing multiple tablets and capsules (6 capsules and 5 tablets) was observed to be placed on the bedside table within reach of the resident. Also, a plastic cup containing approximately 4 ounces of a light orange-colored liquid was sitting on the table next to the med cup. When the resident was asked about the medications, he stated the nurse had put them there for him and he planned to take them with his breakfast.

An interview was conducted on 7/13/21 at 8:55 AM with Nurse #3. At that time, Nurse #3 was outside of the Resident #23's room standing at the med cart (not within view of the resident). During the interview, the nurse was asked if she would typically leave medications for a resident to take on his/her own. Nurse #3 stated she would not do so for residents who were not alert and oriented. When asked if she typically watched alert and oriented residents take their

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medications, she stated she would put the medications down for the resident to take and then go on to administer medications to his or her roommate.

An interview was conducted on 7/15/21 at 10:45 AM with the facility ' s Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified regarding a resident ' s self-administration of medications and the safe / secure storage of the medications were discussed. When asked, the DON reported staff needed to be at bedside and observe the residents take all of their medications before walking out of the room.

2. Resident #39 was admitted to the facility on 12/8/20 with diagnoses that included congestive heart failure, spinal stenosis and hypertension.

A review of the significant change Minimum Data Set (MDS) assessment dated 5/27/21 revealed Resident #39 was cognitively intact.

A review of Resident #39's current physician orders revealed a medication order was received on 3/2/2021 for Flonase suspension to be administered, 1 spray in each nostril one time per day at 8:00 AM. There was no specific order for the type of Multi Vitamins in the physician orders. No notes in the MD order indicated the resident may administer the medication himself. Further review of the resident's medical record revealed no assessments were completed for the self-administration of medication.

An observation and interview were conducted with Resident #39 on 7/12/21 at 11:49AM. The resident was awake, alert and sitting on his bed.

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F 554	Continued From page 9 A bottle of Flonase suspension and a bottle of Multi Vitamins was observed to be placed within the resident's reach on the bedside table next to the resident's bed. Resident #39 reported the nurse had set the Flonase suspension on his bedside table for self-administration when he awoke. He further revealed his family had provided the bottle of Multi Vitamins on 7/10/21. An observation was conducted on 7/13/21 at 8:52AM of Resident 39's room from the hallway. The resident was observed sleeping in bed. The Flonase suspension was no longer on the bedside table. The Multi Vitamins were observed on the bedside table. An interview with the Unit Manager on 7/14/21 at 3:30PM revealed Flonase suspension or Multi Vitamins should never be left at the bedside. She further stated Resident #39 should not self-administer this medication. The Unit Manager educated Resident #39 on keeping medications in the room, removed the Multi Vitamins and secured them in the Med Cart. An interview with the Director of Nursing on 7/15/21 at 4:30PM revealed residents should not self-administer medication unless they had been assessed to safely administer medications. She further stated medication should never be left at a resident's bedside.	F 554		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		8/4/21

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

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F 623	Continued From page 12 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to send a written notice of the reason for discharge to the Responsible Party for 2 of 2 residents reviewed for hospitalization (Resident #64 and #176). This practice had the potential to affect all residents discharged to the hospital. The findings included: 1. Resident #64 was admitted to the facility on 4/14/16 with multiple diagnoses. Review of the clinical record revealed the resident was discharged to the hospital on 1/16/21, 4/19/21 and 6/15/21. On 7/15/21 at 9:30 AM the Social Worker stated in an interview that she sent a list of discharges to the Ombudsman once a month but was not aware a written letter was supposed to be sent to the Responsible Party (RP) when a resident was discharged to the hospital. The Administrator stated in an interview on 7/15/21 at 10:18 AM that they verbally notify the RP when a resident was discharged to the	F 623	F 623 Written notification of discharge 1. Resident #64 returned to the facility. Resident #176 did not return to the facility. 2. Residents with facility initiated transfers have the potential to be affected. 3. Residents who have a facility initiated transfer or discharge to the hospital will be reviewed in the morning meeting Monday through Friday. The transfer/discharge form will be completed by the Business Office Manager (BOM) the morning after transfer/discharge and weekend transfers will be addressed on Monday. The completed form will be mailed by the BOM. The BOM was educated on 7/15/21 of the process. Immediate implementation of notice of transfer form was completed for resident discharged from facility once expectation identified. 4. The Administrator will conduct weekly	

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F 623	Continued From page 13 hospital but was not aware that a written notice to the RP was required when a resident was discharged to the hospital and this had not been done. 2. Resident #176 was admitted to the facility on 5/24/20 with multiple diagnoses. Review of the clinical record revealed the resident was discharged to the hospital on 6/29/21. On 7/15/21 at 9:30 AM the Social Worker stated in an interview that she sent a list of discharges to the Ombudsman once a month but was not aware a written letter was supposed to be sent to the Responsible Party (RP) when a resident was discharged to the hospital. The Administrator stated in an interview on 7/15/21 at 10:18 AM that they verbally notify the RP when a resident was discharged to the hospital but was not aware that a written notice to the RP was required when a resident was discharged to the hospital and this had not been done.	F 623	audits and report the results of the audits to the QA committee monthly for three months and longer if deemed necessary by the committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Preadmission Screening and Resident Review (PASRR) Level II status (Resident #45) and	F 641	F641 Accuracy of Assessments 1. Resident #45 had a corrected assessment submitted 7/14/21. Resident #45 did not have a negative outcome as a	8/4/21

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F 641	Continued From page 14 discharge location (Resident #73) for 2 of 26 sampled residents reviewed for MDS accuracy. The findings included: 1. Resident #45 was admitted to the facility on 7/22/19 with a cumulative diagnoses which included schizoaffective disorder (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder). Review of the resident's electronic medical record included a PASRR Level Determination Notification letter dated 7/22/19. The letter indicated Resident #45's PASRR number ended with the letter "B," which is indicative of a PASRR Level II determination with no limitation on the timeframe (unless there is change in condition). Determination of a PASRR Level II status is made by an in-depth evaluation. Results of the evaluation are used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. Resident #45's most recent comprehensive MDS was an annual assessment dated 7/29/20. Section A of the MDS assessment included Patient Information and indicated the resident was not considered by the State Level II PASRR process to have a serious mental illness and/or intellectual disability. An interview was conducted on 7/14/21 at 3:40 PM with the facility's Social Worker (SW). During the interview, the SW was asked if Resident #45 was a PASRR Level II resident. The SW responded, "Yes, due to her diagnosis."	F 641	result of this finding. Resident #73 had a corrected assessment submitted 7/15/21. Resident #73 did not have a negative outcome as a result of this finding. 2. Audits of completed MDS of past 30 days were completed on 7/14/21 and 7/19/21. No other residents were noted to be affected and no inaccurate assessments found. 3. The Administrator/Regional Clinical Director conducted re-education regarding PASRR II coding accuracy and discharge destination accuracy with the MDS nurses on 7/15/2021. The Regional Clinical Process Analyst conducted additional re-education on PASRR II coding and correct discharge destination coding with the MDS nurses on 7/29/2020: no inaccuracies found. 4. Audits will be conducted three times a week for eight weeks by the Administrator/designee regarding accurate coding of PASRR II and discharge location. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings for 3 months. The QA & A committee will determine need for further auditing beyond 3 months.	

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An interview was conducted on 7/14/21 at 3:49 PM with the facility's MDS nurses. Upon review of Resident #45's PASRR Level Determination Notification letter of 7/22/19, MDS Nurse #1 confirmed the letter determined this resident had a PASRR Level II status. MDS Nurse #2 reported it looked like a mistake was made with coding Resident #45's PASRR status on her 7/29/20 annual MDS assessment. She stated the error needed to be corrected.

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Director of Nursing (DON) and Nurse Consultant. During the interview, the incorrect coding of Resident #45's PASRR status on her 7/29/20 annual MDS was discussed. The Administrator reported she would expect the resident's MDS assessment to be coded accurately.

2. Resident #73 was admitted to the facility on 4/6/2021 with diagnosis that included heart failure, hypertension, and diabetes.

Resident #73's electronic medical record included physician orders dated 5/21/2021 that read in part "discharge home with home health."

Resident #73's Minimal Data Set (MDS) dated 5/21/2021 indicated discharge was to an acute hospital and discharge return not anticipated.

An interview was conducted on 7/15/2021 at 9:57 A.M. with MDS Nurse #2. During the interview the MDS Nurse #2 stated she was made aware of resident discharge locations during one of two staff meetings held weekly. Upon review of Resident #73's electronic medical record, the

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F 641	Continued From page 16 MDS Nurse #2 stated Resident #73's MDS was coded inaccurately. Resident #73's was discharged home and the MDS was coded as an acute hospital discharge instead of a community discharge. An interview conducted on 7/15/2021 at 1:13pm with the facility's Administrator. During the interview the Administrator stated staff were responsible to code the MDS based off resident information obtained during weekly meetings. The Administrator further stated she expected the MDS to be coded accurately.	F 641		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and interviews with a physician's assistant, and the hospital physician the facility failed to use 2 persons when transferring a resident with a mechanical lift according to the care plan for 1 of 1 resident (Resident #176) reviewed for accidents. The resident slid out of the lift pad onto the floor during the transfer and sustained multiple injuries that resulted in a spleen laceration, subarachnoid hemorrhage and rib fractures.	F 689	Past noncompliance: no plan of correction required.	8/4/21

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The findings included:

Resident #176 was admitted to the facility on 5/24/20 and had a diagnosis of multiple sclerosis and age-related osteoporosis.

The resident's active care plan noted the resident was at risk for falls and an intervention dated 1/13/21 was to be transferred with two staff members using a mechanical lift into a motorized wheelchair.

The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 6/1/21 revealed the resident was cognitively intact and required total assistance with 2 persons for transfers. The MDS noted the resident had impaired range of motion of the upper extremities on one side and impaired range of motion of the lower extremities on both sides.

A nursing progress note dated 6/29/21 at 11:35 AM written by the Director of Nursing (DON) revealed the following: The DON was called to the resident's room and observed the resident lying on the floor. The resident was awake and alert and denied pain. The pelvis was manipulated with no pain. Shoulders checked with no complaints of pain or discomfort. Elbows and wrist flexed and checked for range of motion with no pain noted. Checked knees with no pain or discomfort noted. No non-verbal symptoms of pain or discomfort. Resident adamant that she was okay and she was not going to the hospital. As resident was being placed in the lift pad for assistance to the wheelchair, observed blood on the pillowcase. Upon rolling resident over, noted a laceration approximately 2 centimeters with active bleeding over top of a small hematoma. Resident

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informed of the need to go to the Emergency Department (ED). Resident was assisted back to bed via mechanical lift and ice applied to the area of bleeding.

A note by the physician's assistant dated 6/29/21 at 2:30 PM noted the resident was evaluated post fall and had an occipital laceration approximately 1.5-2 centimeters in length observed with active bleeding. Resident was alert and oriented times 3 (person, place and time). Resident became nauseated with positional changes. Informed nursing staff to send to the ED for further evaluation.

A nursing progress notes documented on 6/29/21 at 3:27 PM by Nurse #1 who was assigned to Resident #174 revealed she was called to the room and observed the resident laying on her back with the mechanical lift next to her. NA #1 stated the resident started having a spasm and slid out of the lift pad and she tried to break the resident's fall with her leg. Range of motion was within normal limits. Resident stated she was okay and did not want to go to the ED. Asked resident several times and she said she was fine and was not in any pain. When turning the resident to put her on the lift pad, noted blood on the back of her head. The resident was transferred back to bed with the mechanical lift. Ice was applied to the back of her head. The physician's assistant in the building assessed and gave new orders to send her to the ED.

On 7/13/21 at 1:39 PM an interview was conducted with NA #1 who stated the resident had an appointment for a haircut on the morning of 6/29/21 and Housekeeper #1 was in the room and she thought as long as she had 2 people in

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the room it was okay to transfer the resident. The NA further stated when she lifted the resident in the lift the resident started shaking and having muscle spasms and slid out of the lift pad onto the floor. The NA stated she tried to break the resident's fall with her knee and the resident landed on the floor. The NA continued and stated she asked Housekeeper #1 to get the nurse. The NA was asked what she expected the housekeeper to do during the transfer of the resident and the NA stated: "I don't even know." The NA stated she was trained after the incident and knows she would need another clinical person in the room with her for a lift transfer.

On 7/16/21 at 9:10 AM a second interview was conducted with NA #1 in the room where Resident #176 resided when in the facility. The NA stated she raised the bed, put the lift pad under the resident and lifted the resident in the air above the bed and was moving the lift to place the resident in a motorized wheelchair when the resident started having spasms and slid out of the lift pad and fell onto the floor striking the NAs thigh/knee area on the way down. The NA stated the lift pad was approximately 4.5 to 5 feet off the floor when the resident slid out of the sling. The NA stated a housekeeper was standing about 3 feet inside the resident's room and she told the housekeeper to get the nurse. NA #1 was asked why she did not get another NA to assist with the transfer and the NA stated: "I just don't know."

On 7/13/21 at 2:10 PM Housekeeper #1 stated in an interview he was in the room and NA#1 had the resident up in the lift and the resident started jerking and sliding and the NA asked him to go get the nurse. The Housekeeper stated he notified the nurse and went back to his

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housekeeping cart.

NA #1's orientation training dated 4/26/21 was reviewed and the NA was checked off as safe with transfers using a mechanical lift. The NA will request assistance as indicated and will use assistive devices according to the plan of care was checked. The NA was checked off as previous experience, demonstrated and/or instructed by the preceptor and return demonstration by the orientee.

On 7/13/21 at 4:17 PM an interview was conducted with the medical records (MR) professional who was also a nursing assistant and checked off NA #1 on the skills checklist during her orientation on 4/28/21. The Medical Records person stated NA #1 was trained to transfer a resident with two persons when using a mechanical lift.

On 7/14/21 at 2:25 PM an interview was conducted with PA #1 who saw the resident after the fall. The PA stated it was not his resident, but he was in the building and was asked to see the resident on the day of the fall. The PA further stated the staff had noted a cut on the back of the resident's head. The PA stated the resident was awake, alert and aware. The PA stated the staff rolled her over onto her side to view the laceration and the resident complained of nausea, so he stopped and told the staff to send her to the hospital.

On 7/14/21 at 2:46 PM an interview was conducted with Nurse #1 who was assigned to Resident #176 on the day of the fall. The Nurse stated she was called to the room. The Nurse further stated the DON came in and assessed the

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resident with good range of motion and no pain. The Nurse further stated there was a pillow under the resident's head and when they picked her up with the lift and transferred her back to the bed they saw blood on the pillow and put an ice pack on the back of her head. The Nurse stated they called a PA that was in the building to assess the resident and the resident complained of nausea. The Nurse stated she gave her a medication for nausea and 911 was called and the resident was taken to the hospital. The Nurse stated prior to the fall the resident could move her upper body but could not move her body below the waist including her legs.

Review of the ED Record dated 6/29/21 revealed the resident was admitted to the ED at 1:35 PM. The ED Physician note revealed the following: An 82 year old female with a past medical history of multiple sclerosis with diffuse contractures and previous oxygen requirement who presented immediately after a fall with a chief complaint of nausea. Today, while transferring in a mechanical lift the patient fell out of the lift. She stated she struck her caregiver's knee before landing on the floor. The patient denied loss of consciousness and stated she remembered the entire event. She is not on blood thinners and denied pain anywhere. The patient's only complaint was nausea. On arrival the patient was in no apparent distress. She was afebrile, heart rate in the 80s, blood pressure 102/54 and oxygen saturation 84 percent on room air trial. The patient improved to 96 percent with 5 liters of oxygen via nasal cannula. The head laceration was irrigated and repaired with staples. At 5:34 PM the patient was found to be hypotensive with a blood pressure of 60/30. The patient stated she felt better and denied pain or any complaints. The patient was

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admitted to the Intensive Care Unit.

The Hospital Discharge Summary revealed the following: On 6/30/21 the patient this morning was hypotensive with worsening shock. Intravenous fluids were provided as well as blood products as her hemoglobin was 5 (low). Imaging was consistent with a spleen laceration, traumatic subarachnoid (brain) hemorrhage and multiple rib fractures. The patient was also found to have a femur/tibia/fibula fracture. The patient was lethargic but arousable. On 7/1/21 the patient remained altered and non-communicative and had more difficulty managing her secretions. The power of attorney decided to focus on comfort measures only and the patient passed on the morning of 7/4/21.

An interview was conducted on 7/15/21 at 12:15 PM with the Trauma Surgeon that cared for Resident #176 while in the hospital. The Trauma Surgeon stated the resident had a laceration to the back of the head and developed a subarachnoid (brain) hemorrhage, had rib fractures with a small pleural effusion (fluid in the lung), a laceration of the spleen and pelvic fractures. The Trauma Surgeon further stated the resident's fractures were acute and the resident's death was directly related to her fall.

Review of the Death Certificate for Resident #176 revealed the following: Immediate cause of death was "Multiple blunt force injuries. Date of injury 6/29/21. How injury occurred: "Fell from (name of mechanical lift.)" Date pronounced: 7/4/21.

On 7/15/21 at 4:28 PM an interview was conducted with the Administrator, DON and the Nurse Consultant. The Nurse Consultant stated

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that it was facility practice for therapy to assess a resident to determine the method of transfer and therapy would give a copy of a communication form with the way the resident was to be transferred to nursing and the DON would get a copy as well. The DON stated she checked the NAs' Kardex (care guide) and if not already on the Kardex she would add the information to the Kardex. The Nurse Consultant stated the lift pad size was based on the resident's weight and Resident #176 was transferred with the correct size lift at the time of the fall. The Administrator stated they had completed a full plan of correction related to the resident's fall. The Nurse Consultant stated Resident #176 required the use of the lift pad with a donut hole and her bottom rested over the hole to keep her in the pad. The Nurse Consultant stated they were unable to use the lift pad that went between the legs due to the resident's legs being contracted. The Nurse Consultant stated they did an investigation and their root cause analysis was that the resident had muscle spasms and was transferred with only one staff member. The Nurse Consultant further stated the staff had been educated to not ask non-clinical staff to assist with transfers of the residents.

Corrective action for resident found to have been affected by the deficient practice:

The affected resident was sent to the hospital and did not return to the facility.

A meeting with the Therapy Director was held to validate the affected resident was utilizing the correct lift. Therapy validated the correct lift was utilized. The clinical team met to ensure the

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correct lift pad was utilized and it was determined the lift pad utilized was appropriate for the resident.

An investigation ensued immediately with a re-enactment of the transfer. The root cause was determined to be the lack of 2 clinical staff assistance with a mechanical lift. The resident experienced muscle spasms and the employee involved was unable to assist the resident independently.

Immediate education was provided to the employee involved. The education included 2 clinical staff required for any mechanical lift transfers. Validation of the involved employee's competency/education prior to 6/29/21 was verified (4/26/21). Written disciplinary action was completed for the employee. Re-education was provided on 6/29/21 to employees involved.

Identification of other residents having the potential to be affected:

All residents who use mechanical lifts have the potential to be affected.

A facility audit was conducted of all residents utilizing a mechanical lift.

Each resident transferred by a mechanical lift was reviewed by the Interdisciplinary Team (IDT) which included the Director of Nursing, Social Worker, Administrator and the Therapy Director.

Therapy referrals were completed for residents who the IDT identified as needing re-evaluation.

Measures to ensure the deficient practice will not

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recur:

Staff education began on 6/29/21 regarding lift transfers and the requirement of having 2 clinical staff for any lift transfers. All clinical staff and therapy staff were educated to include the need for 2 clinical staff members for all mechanical lift transfers. Non-clinical staff were educated as well to inform they were not to assist/be the second person for lift transfers. All employees were educated.

Staff education for clinical staff included validation of comprehension and return demonstrations with two clinical employees present. The education included safety components of the mechanical lift transfers. All staff education and competencies were completed by 7/6/21.

A QAPI (Quality Assurance and Performance Improvement) meeting was held on 6/29/21 and 6/30/21 which included the Medical Director to review the investigation and the education.

Monitoring of the performance of the measures put in place:

Daily audits will be conducted on random residents requiring mechanical lift transfers for 4 weeks, weekly for 4 weeks and monthly for 3 months.

The audits will be reviewed in the monthly QAPI meetings with any recommendations to ensure compliance is maintained.
The QAPI committee will determine the need for further auditing or ongoing education.

QAPI meetings were held on 6/29/21 and 6/30/21

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F 689	Continued From page 26 which included the Medical Director, to review the investigation and the education. All components of the plan of correction were completed by 7/6/21. The audits are on-going to ensure compliance. The corrective action plan was validated on 7/16/21 and it was concluded the facility had implemented an acceptable corrective action plan on 7/6/21. Review of staff education materials and sign in sheets for the education were reviewed to determine that education was provided for all staff and the nurses and NAs did a return demonstration of a mechanical lift transfer during the education. Review of facility documents revealed audits were being done per the facility's plan of correction. Interviews were conducted with nurses and NAs in the facility who confirmed they received education regarding transfers with a mechanical lift and all transfers with a mechanical lift were to be done with 2 clinical staff members. Interviews were conducted with dietary and housekeeping personnel who verified they received education they were not to assist with mechanical lift transfers. Observations were made of residents being transferred with a mechanical lift and 2 clinical staff were used during all transfers observed.	F 689		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		8/4/21

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F 759	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 25 opportunities, resulting in a medication error rate of 16 percent for 2 of 6 residents (Resident #59 and Resident #18) observed during medication pass. The findings included: 1-a. On 7/14/21 at 9:11 AM, Nurse #3 was observed as she prepared medications for administration via a gastrostomy tube (G-Tube) to Resident #59. The medications included 10 grams (g) / 15 milliliters (ml) lactulose (a medication which may be used to manage constipation). The nurse stated she was going to measure out 20 ml of lactulose and was observed as she used a medication cup to measure the medication. The measurement of 20 ml lactulose was confirmed by observation. Nurse #3 was observed as she administered the medication via Resident #59 ' s G-Tube. A review of Resident #59 ' s current medication orders included: 20 g / 30 ml (equivalent to 10 g / 15 ml) to be given as 15 ml (providing a dose of 10 g lactulose) via G-Tube one time a day for constipation. An interview was conducted on 7/14/21 at 9:36 AM with Nurse #3. When asked, the nurse confirmed she measured out and administered 20 ml of lactulose to Resident #59. Upon review of the resident's order on her Medication Administration Record (MAR), the nurse stated,	F 759	RR 759 Medication error rates 1. Resident #59's MD was notified regarding the medication error. No new orders were given. 2. Resident #18's MD was notified regarding the medication error. No new orders were given. Education was provided on 7/14/21 to Nurse #3 and Nurse #4 regarding proper medication administration via G tube and verification for medication administration. 2. The DON/Designee will conduct education with licensed nurses beginning 7/14/2021. Licensed nurses were educated by 8/2/2021 on the administration of medications by g-tube and the verification for medication administration. 3. Medication Administration audits will be conducted weekly starting the week of 7/25/21 for six weeks to ensure proper g-tube medication administration and to ensure medication error rates below 5%. The audits will be conducted by the DON/Designee. Any concerns will be addressed with follow up education. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as	

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"Oh....it's 15 (milliliters)." Nurse #3 reported 15 ml of lactulose (not 20 ml) should have been administered to Resident #59.

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication administration observation were discussed. The DON reported she would expect nurses to follow the facility's policies they have been educated on multiple times, including those regarding the administration of medications via a G-Tube. She stated all nurses learn the 5 rights of medication administration (the right patient, the right drug, the right dose, the right route, and the right time). The DON reported if a nurse had a question, he/she should ask for clarification.

1-b. On 7/14/21 at 9:11 AM, Nurse #3 was observed as she prepared medications for administration via a gastrostomy tube (G-Tube) to Resident #59. The medications included 40 milligrams (mg) / 5 milliliters (ml) famotidine suspension (a medication used to treat GERD). The nurse stated she was going to measure out 5 ml of famotidine and was observed as she used a medication cup to measure the medication. The measurement of 5 ml famotidine was confirmed by observation.

A review of Resident #59 ' s current medication orders included: 20 milligrams (mg) famotidine suspension to be given via G-Tube two times a day for GERD. A 20 mg dose of famotidine would be provided by administering 2.5 ml of the 40 mg/5 ml famotidine suspension.

An interview was conducted on 7/14/21 at 9:36

deemed necessary/appropriate by this committee

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AM with Nurse #3. When asked, the nurse confirmed she measured out and administered 5 ml of famotidine suspension to Resident #59. Upon review of the resident's order on her Medication Administration Record (MAR), Nurse #3 acknowledged 2.5 ml of famotidine suspension (not 5 ml) should have been administered to Resident #59.

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication administration observation were discussed. The DON reported she would expect nurses to follow the facility's policies they have been educated on multiple times, including those regarding the administration of medications via a G-Tube. She stated all nurses learn the 5 rights of medcation administration (the right patient, the right drug, the right dose, the right route, and the right time). The DON reported if a nurse had a question, he/she should ask for clarification.

1-c. A review of the facility ' s policy, "Medication via Gastrostomy Tube" (Revised 4/24/18) included the following Steps in the Procedure, in part:
#4. (of 23 steps) " ...Crush tablet(s) individually and put in separate medication cups with diluent (water) as per order and mix well ...
#16. (of 23 steps) Once residual is verified, flush tube with water as per physician's order prior to administering the first medication.
#17. Administer each medication separately.
a. Flush tube before and after meds and with a minimum of 5 cc (cubic centimeters) between each medication or per the ordered amount by physician ...

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e. Flush tube with water as per order after the last medication is administered."

On 7/14/21 at 9:11 AM, Nurse #3 was observed as she prepared medications for administration via a gastrostomy tube (G-Tube) to Resident #59. The medications included: 20 milliliters (ml) of a 10 grams (g) / 15 ml lactulose solution (a medication which may be used to manage constipation); 5 ml of a 40 milligram (mg) / 5 ml famotidine suspension (a medication used to treat GERD); one - 81 mg chewable aspirin tablet; and one - 10 mg amlodipine tablet (an anti-hypertensive medication).

Nurse #3 was observed as she crushed the aspirin and amlodipine tablets together and placed them in a cup. She added 30 cc water to the cup and stirred the contents together to dissolve the crushed tablets. Next, Nurse #3 measured out 20 ml lactulose solution and poured it into a plastic cup. She then measured out 5 ml famotidine suspension and poured it into the same plastic cup containing the lactulose. The nurse stirred the lactulose and famotidine together in the cup.

Nurse #3 was observed as she brought the medications into Resident #59's room for administration. The nurse checked for placement of the G-Tube, then drew up the solution of the crushed tablets and water with a syringe and instilled the solution into the G-tube. Next, Nurse #3 was observed as she drew up the mixture of lactulose solution and famotidine suspension into the syringe and instilled the liquid medications into the G-tube. Plain water flushes were not observed to be given prior to the administration of the medications or between the medications

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being administered.

After the medications were administered to Resident #59, Nurse #3 returned to the medication cart. The nurse was observed as she reentered the resident's room with approximately 60 cc of water, stating she was going to use the water to flush the tube.

A review of Resident #59's current orders included the following, in part: Check G-tube placement every shift, before administration of meds and flushes; and, flush G-Tube with 30 cc water before and after meds with 5 cc water between each medication.

An interview was conducted on 7/14/21 at 9:36 AM with Nurse #3. During the interview, inquiry was made with regards to flushing Resident #59's G-Tube with water before meds were administered and flushing with water between each medication (administered individually) via G-Tube. The nurse stated "they" have always mixed the initial water for flushing a G-Tube with the meds and crushed the meds together. When asked what the facility's policy instructed her to do, she reported she was not sure. Nurse #3 stated she was not aware the medications should be given individually with water flushes instilled between each medication given.

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication administration observation were discussed. The DON reported she would expect nurses to follow the facility's policies they have been educated on multiple times, including those

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regarding the administration of medications via a G-Tube.

2. On 7/14/21 at 4:30 PM, Nurse #4 was observed as she prepared and administered medications to Resident #18. The medications included one - 10 milligrams (mg) tablet of clobazam (an anticonvulsant medication) administered by mouth.

A review of Resident #18's current medication orders included 10 milligrams (mg) clobazam film to be given as one film by mouth for seizures (scheduled for 4:00 PM administration).

An interview with Nurse #4 was conducted on 7/14/21 on 4:50 PM. During the interview, the nurse reviewed the resident's MAR and medications available on the med cart. Clobazam (10 mg) was available on the medication cart for Resident #18 in two dosage forms (both as a 10 mg tablet and a 10 mg film). Nurse #4 reported she knew the resident's clobazam was being changed from a tablet to a film dosage form but didn't realize it had come in from the pharmacy. The nurse confirmed she administered the wrong dosage form of clobazam to Resident #18.

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication administration observation were discussed. The DON stated all nurses learn the 5 rights of medication administration (the right patient, the right drug, the right dose, the right route, and the right time). She reported if a medication's dosage form didn't match the form

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F 759	Continued From page 33 indicated in the order, the nurse needed to make the practitioner aware. The DON stated either an order needed to be provided for the dosage form currently available for administration to the resident or the facility needed to obtain the correct dosage form of the medication as indicated by the provider ' s order.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 761	F761 Drug Storage	8/4/21

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F 761	Continued From page 34 facility failed to identify and remove expired medications stored in 2 of 3 medication carts observed (4-A Med Cart and 2-A Med Cart). The findings included: 1. Accompanied by Nurse #1, an observation was made on 7/12/21 at 3:23 PM of the 4A Medication Cart. A bubble pack medication card containing 6 tablets of 4 milligrams (mg) ondansetron (a medication used to treat nausea and/or vomiting) were identified as being stored on the med cart. The medication label indicated it was dispensed from the pharmacy on 7/15/20 for Resident #48. A review of the pharmacy labeling revealed the medication's expiration date was 3/31/21. An interview was conducted on 7/12/21 at 3:30 PM with Nurse #1. Upon review of the pharmacy labeling on the ondansetron, the nurse confirmed this medication was expired. Nurse #1 reported an expired medication would need to be removed from the medication cart and sent back to the pharmacy. An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication storage observations were discussed. The DON reported she would expect nursing staff to check a medication's expiration date prior to the med being administered to a resident. If a medication was identified as expired, she would expect it to be taken off of the med cart and sent back to the pharmacy. 2-a. Accompanied by Nurse #2, an observation was made on 7/14/21 at 10:00 AM of the 2A	F 761	1) The expired medications were removed and immediately discarded. 2) All of the facility medication carts were inspected for expired medications on 7/14/2021 by the DON. No further expired medications located. 3) Nursing education was provided 7/14/2021-8/2/2021, the education included medication cart audits for expired medications to be conducted by the 11-7 nurse (or 7P-7A if 12 hour shift). The audits were added to the night shift duties checklist. Medication cart and medication storage rooms will be checked by the DON/designee every Monday. Expiration dates to be checked in medication cart and prior to being administered to residents. 4) DON/designee will perform a medication cart audit weekly X 6 weeks, then monthly X 3 months. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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Medication Cart. A stock box containing 13 hemorrhoidal suppositories with a manufacturer expiration date of March 2021 was identified as being stored on the med cart.

An interview was conducted on 7/14/21 at 10:10 AM with Nurse #2. Upon review of the manufacturer's labeling on the box of hemorrhoidal suppositories, the nurse confirmed the medication was expired. Nurse #2 stated, "I'll get rid of them."

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication storage observations were discussed. The DON reported she would expect nursing staff to check a medication's expiration date prior to the med being administered to a resident. If a medication was identified as expired, she would expect it to be taken off of the med cart and sent back to the pharmacy.

2-b. Accompanied by Nurse #2, an observation was made on 7/14/21 at 10:00 AM of the 2A Medication Cart. A stock supply of 2 - 10 milligrams (mg) bisacodyl suppositories (a medication used to treat constipation) with a manufacturer expiration date of December 2020 was identified as being stored on the med cart.

An interview was conducted on 7/14/21 at 10:10 AM with Nurse #2. Upon review of the manufacturer's labeling on the bisacodyl suppositories, the nurse confirmed the medication was expired. Nurse #2 stated, "I'll get rid of them."

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An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication storage observations were discussed. The DON reported she would expect nursing staff to check a medication's expiration date prior to the med being administered to a resident. If a medication was identified as expired, she would expect it to be taken off of the med cart and sent back to the pharmacy.

2-c. Accompanied by Nurse #2, an observation was made on 7/14/21 at 10:00 AM of the 2A Medication Cart. A stock supply of 1 - 10 milligrams (mg) bisacodyl suppository (a medication used to treat constipation) with a manufacturer expiration date of June 2020 was identified as being stored on the med cart.

An interview was conducted on 7/14/21 at 10:10 AM with Nurse #2. Upon review of the manufacturer's labeling on the bisacodyl suppository, the nurse confirmed the medication was expired. The nurse reported she would "get rid" of the suppository.

An interview was conducted on 7/15/21 at 10:45 AM with the facility's Administrator, Nurse Consultant, and Director of Nursing (DON). During the interview, concerns identified during the medication storage observations were discussed. The DON reported she would expect nursing staff to check a medication's expiration date prior to the med being administered to a resident. If a medication was identified as expired, she would expect it to be taken off of the med cart and sent back to the pharmacy.

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(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) COMPLETION DATE
F 908	Continued From page 37	F 908		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to maintain the fryer in safe operating equipment for 1 of 1 fryer in the kitchen. Findings included: The Gas Fryer manufacturer's Installation, Operation, and Maintenance Manual dated 4/2019 stated the following step to light the pilot light "push and hold the knob in and apply a lighted match to the pilot burner head". The manual further stated, "If the pilot fails to remain lit, turn the gas valve off and wait 5 minutes before attempting to re-light". Observations made on 7/12/2021 at 11:10 A.M revealed the Dietary Manager held an eight-inch-long piece of paper in his hand and walked from the stove burner to the left where the fryer unit was positioned. The Dietary Manager opened the front door of the fryer to access to pilot light and held the paper inside the unit. Next the Dietary Manager walked to the trash can on the right side of the stove and threw the paper away. The Dietary Manager then repeated the above steps with a new second piece of paper. An interview was conducted with the Dietary Manager on 7/12/2021 at 11:14 A.M. The Dietary Manager stated the fryer was not broke, the pilot	F 908	F908 Essential Equipment, safe operating conditions 1- No residents were affected by the deficient practice 2- On 7/13/21 immediate re-education was provided to the Dietary Manager by the Administrator regarding the manufacturer’s instructions and appropriate lighter source for the pilot light on the fryer. On 7/13/21 the fryer was removed from service A new fryer was installed on 7/16/21 3. The Maintenance Director provided safe operating instructions for the new fryer which included the appropriate and safe lighting of the pilot light on the fryer with appropriate lighter source. The pilot light will remain on at all times. The dietary staff were instructed/educated to call Maintenance if fryer is not functioning correctly. 4. The Maintenance Director will conduct audits of the fryer weekly for 4 weeks and then monthly thereafter. Results of audits will be reviewed during QA & A Committee monthly for 3 months.	8/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 07/16/2021

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F 908	Continued From page 38	F 908	QA & A Committee will review audits and make recommendations based on outcomes.	

light was extinguished by air from the stove hood. The Dietary Manager was unable to state how long he had been relighting the pilot light due to the infrequent use of the fryer in food preparation. The facility rotated a six-week menu cycle that required only two or three fried options during the cycle. During the interview the Dietary Manager stated he always used paper to relight the fryer's pilot light and no other kitchen staff were responsible to relight the pilot when it was extinguished. The Dietary Manager revealed due to the age of the current fryer used in the kitchen, a new fryer was ordered to replace the older fryer. When the new fryer arrived at the facility, a work order was submitted for the new fryer to be installed.

An interview was conducted with Nutritional Service Staff #1 on 7/13/2021 at 9:55 A.M. It revealed the pilot light on the fryer periodically went out while staff prepared meals. The Nutritional Service Staff #1 stated not many meals required the use of the fryer and she was unsure how long the pilot light had gone out during meal preparations. Nutritional Service Staff #1 further stated when the light went out, she contacted maintenance to relight the pilot because she was unsure how to light the pilot herself. During the interview the Nutritional Service Staff #1 stated she was unsure how maintenance relit the pilot light.

An interview with Maintenance Staff #1 on 7/13/2021 at 10:10 A.M. revealed to his knowledge the pilot light in the kitchen went out one time in March or April 2021. Maintenance Staff #1 further stated he contacted the Maintenance Director to relight the pilot light because he was unsure how to relight the fryer's

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F 908	Continued From page 39 pilot light. An interview with the Maintenance Director on 7/13/2021 at 10:03 A.M. revealed he was never contacted to relight the fryer light in the kitchen and to his knowledge the fryer pilot was not broken. The Maintenance Director stated due to the fryers equipment's age, a new fryer had been ordered to replace the old unit and the new fryer was scheduled to be installed. The Maintenance Director stated he had never been asked to relight the pilot light and was unsure how to light the fryer's pilot light. An interview was conducted with the Administrator on 7/13/2021 at 3:05 P.M. The Administrator stated staff were responsible to follow the manufacturer's instructions for equipment and use an appropriate lighter source when lighting the pilot light on the fryer.	F 908		