STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	C 08/20/2021

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PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

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E 000	Initial Comments An unannounced recertification survey was conducted on 8/17/2021 through 8/20/2021. The facility was found in compliance with the requirement CFR483.73, Emergency preparedness. Event ID # C37C11,	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted on 8/17/2021 through 8/20/2021. There were 7 allegations investigated and all were unsubstantiated. Event ID # C37C11. The Statement of Deficiencies was amended on 09/07/21 to reflect the deletion of F 636 based on additional information submitted by the facility.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon	F 565		9/9/21

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

Electronically Signed | 09/10/2021

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F 565	Continued From page 1 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to respond in writing and resolve repeat concerns related to menu availability voiced by resident council for 3 of 3 resident council meetings. The findings included: Review of resident council minutes dated 05/26/21, 06/26/21 and 07/28/21 revealed the residents voiced concerns regarding not receiving menus for lunch and supper on weekends. There was no further documentation regarding procedures developed or interventions regarding residents not getting menus on the weekends. The minutes did not contain any documentation to support old business conducted. Review of individual grievance reporting form dated 5/26/21 revealed no menus on the	F 565	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F 565 Affected Residents No resident was named in this alleged noncompliance. The Director of Activities invited all facility residents to attend the resident council meeting on 8/31/2021. At resident council meeting on 8/31/2021, old business of resident concerns, including the concern regarding unavailability of menus on the weekend, was reviewed with resident council. Copy of written response to	

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F 565	Continued From page 2 weekends. The form further revealed that all staff was in serviced on menus. Review of individual grievance reporting form dated 7/28/2021 revealed no menus being offered on the weekend. All staff was in serviced on menus and NAs not returning the menu sheets or returning them blank. Interview with the resident council president (Resident #39) on 08/18/21 at 12:55 PM revealed the resident council did not receive a response to not receiving menus on the weekends. Resident #39 explained the group voiced the concern In May, June and July and was an ongoing issue. Interview with the Activity Director (AD) on 08/18/21 at 9:31 AM revealed the resident council's concern with not receiving weekend menus was documented through resident council minutes and individual grievance reporting form. She further revealed that she forwarded the forms to the Director of Nursing (DON). Interview with District Dietary Manager (DM) and Facility Dietary Manager on 08/20/21 01:39 PM revealed grievances were not always hand delivered but were also placed in her box. She stated the resident council minutes were not reviewed by dietary, they were transferred to an individual grievance form. She would then interview each resident and write her findings with a resolution. She indicated she first became aware on 7/28/21 that menus were not being made available on the weekends by means of the individual grievance reporting form. She responded to the grievance by in servicing staff and ensuring menus were available Although she had made the menus available NAs indicated	F 565	individual concerns presented during meeting. There were no additional concerns regarding unavailability of menus on the weekend. 100% audit of the Resident Council minutes for the past 90 days were reviewed by the Administrator and the Activities Director on 8/25/2021 to identify any other unresolved, repeated grievances. There were no additional concerns identified. No residents were affected by the alleged deficient practice. Systemic changes The Activity Director was educated by the facility Administrator on 8/24/2021 regarding the following: " Procedures for resident council meetings. " Process for reporting resolutions to concerns addressed during the meeting " Process for providing written responses to concerns presented during resident council meeting " Documentation of resident council meetings " Review of old business minutes for follow up and resolution The Activity Director will document Resident Council concerns/problems in Resident Council Minutes. Individual concerns will be addressed on the Grievance Reporting Form and turned into the Administrator upon completion of the Resident Council Meeting. The Activity Director will notify the Administrator immediately informed of any urgent issues, council concerns, or problems. The Activities Director will validate	

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F 565	Continued From page 3 they did not have time to distribute them. They stated they were unaware of the individual grievance form from resident council dated 5/26/21. It was reviewed by a previous employee. Interview with the DON on 08/20/21 at 2:38 PM revealed she had made the charge nurse aware of the grievance regarding menus not being provided to residents on the weekend. She stated the charge nurse had identified that menus were not being left for nurse aides (NAs) to provide to residents. Dietary staff were supposed to leave the weekend menus with the NAs. She was under the impression that the menus were being made available on the weekends. She was unaware this was an ongoing issue. Interview with the Administrator on 08/20/21 at 3:26 PM revealed the resident council should receive a response to concerns. He stated activity director was responsible for disturbing resident council concerns to the appropriate department. He signs off on resident council minutes. He stated that old business should be addressed each month. The resolved should be placed on the old business for the following month.	F 565	completion of both the Resident Council Minutes form and the corresponding response on the Grievance Reporting Form. The Activities Director or designated person will then present back to the Resident Council the resolutions to the previous meeting. The Administrator and DON may attend if invited by the resident council to address the facility responses. The Administrator will review all resident council minutes to ensure that all responses and resolutions have been presented back to the resident council. The Dietary Manager educated all weekend dietary staff on 8/4/2021 to ensure that menus were provided to all residents on the weekend. Any dietary staff out on leave or PRN status will be educated on this prior to returning to duty by the Dietary Manager. Newly hired dietary staff will be educated on this during orientation process by the Dietary Manager. There have been no further concerns regarding the unavailability of menus on the weekend. Monitoring: An audit tool that was developed to ensure compliance with the plan of correction. The audit includes the following: " Are menus being distributed to residents on the weekends? " Are resident council concerns being addressed and resolutions reported back to the resident council? The Administrator will review resident council minutes for proper facility	

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F 565	Continued From page 4	F 565	procedures for resident council meetings, to ensure concerns have been addressed and resolutions reported back to resident council and to ensure old business conducted is reviewed with concerns being resolved. This audit will be conducted monthly x 3 months. . The results of the audits will determine the need for further monitoring. An audit tool was developed to ensure that menus were provided to residents on the weekends. The weekend Registered Nurse Supervisor will audit 5 random residents every weekend for 1 month, then every other weekend for 1 month, then monthly for 1 month. The results of these audits will determine the need for further monitoring. QAPI The Administrator will bring audits to the Quality Assurance and Performance Improvement Committee monthly for review and further recommendations monthly to ensure compliance with the plan of correction.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		9/10/21

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F 583	Continued From page 5 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide privacy and confidentiality of medical records when a resident's electronic medical record was visible and unattended on 1 of 1 medication cart computer for 1 of 1 resident reviewed for privacy (Resident #374). Findings included: Resident #374 was admitted to the facility on 08/11/21. Resident #374's diagnoses included long term drug therapy, abnormal blood chemistry	F 583	F 583 Resident affected: On 08/20/2021, immediate retraining was conducted by the Staff Development Coordinator (SDC) with Nurse #1 regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. Resident #374 was not adversely affected by the alleged deficient practice. Other residents with potential to be	

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F 583	Continued From page 6 and acute osteomyelitis of the right hand. Resident #374 did not have a minimum data set available for review. A continuous observation was completed on 08/19/21 from 11:31 AM until 11:35 AM on the 500 hall. The 500 hall medication cart was stationed outside of Resident #374's room. The medication cart faced away from the wall into the hallway and had a laptop computer mounted on the top of the medication cart. Resident #374's medication administration information was visible on the computer screen. Nurse #1 was responsible for the medication cart and the computer. She was observed in the room with Resident #374. At 11:33 AM, Nurse #1 left Resident #374's room, walked past the computer and medication cart and went down the hallway towards the nurse's station. At 11:35 AM, the laptop screen blacked out and Resident #374's medication administration information was no longer visible on the screen. During the time Resident #374's medication administration information was displayed on the computer screen, 5 staff members walked past the laptop. An interview was conducted with Nurse #1 on 08/19/21 at 3:45 PM. Nurse #1 stated she would pull the laptop screen down before walking away from the medication cart. Nurse #1 indicated she was "flustered" and had not been aware of leaving Resident #374's medication administration information visible on the computer screen. During an interview on 08/19/21 at 3:48 PM, the Unit Manager indicated that nurses should pull down the computer screen or otherwise protect	F 583	affected: All residents have the potential to be affected by this alleged deficient practice. A 100% audit was completed on 08/20/2021 by the SDC and Director of Nursing on all medication carts to ensure that all electronic medical records were closed, and no electronic medical record was left unattended, exposing resident□s personal and medical information in an area accessible to the public. No identified areas of concerns were identified during this audit. No additional residents were identified to have been affected by the alleged deficient practice. System changes: The Director of Nursing (DON) and Staff Development Coordinator will educate all licensed personnel on the policy regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. This education will be completed by September 10, 2021. Any licensed personnel out on leave, vacation or PRN status will be educated prior to returning to their assignment by the SDC and/or DON. All newly hired licensed personnel or contracted licensed personnel will be educated on this policy during orientation by the SDC or DON. Monitoring: 100% of Electronic Medical Records on the Medication Carts will be monitored using an audit tool to ensure all electronic medical records are closed to protect private health information when left unattended in an area accessible to the	

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F 583	Continued From page 7 resident privacy when they walked away from the computer so that medication administration information was not displayed. An interview was conducted with the Director of Nursing (DON) on 08/20/21 at 10:41 AM. She revealed nurses should close their computer screen when they walked away from medication carts. She indicated nurses were trained on this process during orientation and as on-going on-the-spot training. On 08/20/21 at 3:45 PM an interview was conducted with Resident #374. He revealed he would not want everybody to know his medical information. Resident #374 stated, "you don't want everybody to know what's going on." During an interview with the Administrator on 08/20/21 at 3:50 PM, he indicated that staff should follow the Health Insurance Portability and Accountability Act (HIPAA) guidelines and protect resident information both verbally and visually. He further revealed the nurse should have protected the resident's information by flipping the computer screen down.	F 583	public. To ensure continued compliance, audits will be conducted by the SDC, DON, or their designee for all medication cart computers on one alternating shift daily for seven days, then one alternating random shift twice a week for three weeks, then one alternating random shift weekly for two months. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		9/10/21

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F 656	Continued From page 8 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan for hospice for 1 of 3 residents reviewed for hospice (Resident #13) and failed to develop a care plan for a tracheostomy for 1 of 1 resident reviewed for tracheostomy (Resident #59).	F 656	F 656 Resident affected: Resident #13 passed away on 8/15/2021. Resident #59 had a comprehensive person-centered care plan developed for tracheostomy on 8/20/2021 by the	

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F 656	Continued From page 9 1. Resident #13 had been discharged return not anticipated on 6/18/2021. She was readmitted from the hospital on 6/21/2021with diagnoses including Alzheimer's disease and sepsis. Hospice services had been arranged by the hospital prior to discharge. A hospital physician consult note dated 6/20/2021 revealed Resident #13 required comfort care and the discharge plan was to return to the facility with hospice services. Review of Resident #13's medical record revealed a hospice admission packet and hospice physician's plan of care dated 6/22/2021. The facility physician orders were reviewed, no order for hospice services was observed. The care plan was reviewed, no hospice care plan or interventions were identified. An interview with the MDS coordinator on 8/18/2021 at 4:32 PM revealed she could not locate a hospice care plan for Resident #13. She explained that the social worker was responsible for the implementation of the hospice care plan. An interview with the social worker on 8/19/2021 at 10:40 AM revealed Resident #13 should have had a care plan in place for hospice. The social worker stated it was her responsibility to ensure a hospice care plan was in place. During an interview with the Director of Nursing (DON) on 8/20/2021 at 2:17 PM she revealed Resident #13 should have had a hospice care plan in place.	F 656	Minimum Data Set Nurse, (MDS Nurse 1). Resident #13 and resident #59 were not adversely affected by the alleged deficient practice. Other residents with potential to be affected: All residents receiving Hospice services and residents with a tracheostomy have the potential to be affected by this alleged deficient practice. All current residents on Hospice and/or who have a tracheostomy were reviewed on 08/20/2021 by the Director of Nursing, (DON) and MDS Nurse to ensure that they had current, comprehensive person-centered care plans. All residents receiving Hospice services and/or residents with a tracheostomy had a comprehensive, person-centered care plan in place. There were no additional residents identified as having been affected by the alleged deficient practice. System changes: The Director of Nursing (DON) and Staff Development Coordinator (SDC) provided education to the MDS Nurse 1 and MDS Nurse 2 on policy of ensuring that any resident on Hospice services and/or who has a tracheostomy has a current comprehensive, person-centered care plan in place. This education was completed on September 8, 2021. Any newly hired MDS nurse will be educated on this policy during orientation by the MDS Nurse on staff. Monitoring: An audit tool was developed to ensure	

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F 656	Continued From page 10 2. Resident #59 had been readmitted from the hospital on 12/23/2020 status post tracheostomy with diagnoses that included malignant neoplasm of the larynx. The hospital discharge summary dated 12/23/2020 revealed Resident #59 had a tracheostomy placed on 12/9/2020. A quarterly Minimum Data Set (MDS) assessment dated 7/19/2021indicated Resident #59 had a tracheostomy. Review of Resident #59's medical record revealed no care plan with interventions for the care of his tracheostomy. An interview was conducted with the MDS coordinator on 8/20/2021 at 8:45 AM. The MDS nurse explained a tracheostomy care plan should have been put into place after Resident #59 returned from the hospital with a tracheostomy. During an interview with the Director of Nursing (DON) on 8/20/2021 at 2:17 PM, she stated Resident #59 should have had a tracheostomy care plan implemented upon his return from the hospital.	F 656	compliance with the plan of correction. The audits include whether residents on Hospice services and/or who have a tracheostomy or who are admitted on Hospice services and/or a tracheostomy have a current, comprehensive, person-centered care plan. Audits will be conducted by the SDC, DON, or their designee. 100% of these residents will be audited weekly for four weeks, then monthly x two months. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		9/9/21

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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 688	Continued From page 11 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to apply a left resting hand splinting device for 1 of 1 resident (Resident #39) reviewed for range of motion (ROM). The findings included: Resident #39 was admitted to the facility on 8/1/2019 with diagnoses that included cerebral vascular accident (CVA) that affected the left side and unspecified osteoarthritis. Review of Resident #39's care plan dated 8/14/2019 revealed she was at risk for skin breakdown related to left side weakness, frequent incontinent episodes and use of braces to left upper and lower extremities. Review of physician order dated 11/18/2019 revealed Resident #39 was to have a left-hand splint applied for up to 4 hours during the day. The order further revealed Resident #39 was to have ROM to her wrist and fingers. Her skin was to be monitored prior to and after removal of her	F 688	F 688 Affected Resident Facility staff performed range of motion exercises to Resident #39 left wrist and fingers and applied the left-hand splint as ordered on 8/20/2021. Her skin was observed before and after placement of the left-hand splint with no identified abnormalities. The resident was not adversely affected by the alleged deficient practice. Residents with potential to be affected All residents with contracture management splints and orders for range of motion exercises have the potential to affected by the alleged deficient practice. The Director of Nursing (DON), Registered Nurse Supervisor, Staff Development Coordinator (SDC) and Social Worker performed a 100% audit of all residents with current contracture management splints and physician orders for range of motion exercises. All residents were receiving range of motion	

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F 688	Continued From page 12 splint from 7:00 AM to 3:00 PM. Special instructions stated prevent contracture of left hand and maintain ROM. Minimum Data Set (MDS) assessment dated 7/5/2021 revealed Resident #39 was cognitively intact, had an upper body extremity impairment and had no behavioral concerns. Occupational therapy (OT) note dated 7/16/2021 revealed Resident #39 was discharged from OT on 7/16/2021 with a left-hand splint. The OT note further revealed Resident #39 was independent with splint wear and care. An observation and interview on 8/17/2021 at 12:23 PM revealed a blue left-hand splinting device in a box in a corner of Resident #39's room out of her reach. Resident #39 stated the splint was supposed to be on her left hand for 4 hours each day. She stated she had a history of a stroke that affected her left side. Resident #39 further stated she could not recall the last time she had the left-hand splint applied. Observation of Resident # 39's left hand revealed resident could open her hand most of the way. She revealed her left hand did better when the splint was applied. Observation of left foot brace revealed that it was in place to left foot. Resident #39 stated the left foot brace was applied daily and she did not have any concerns regarding left foot brace. Follow up observations were completed on 8/17/2021 at 4:45 PM, 8/18/2021 at 10:05 AM, 8/18/2021 at 1:05 PM, 8/18/2021 at 5:30 PM, and 8/19/2021 at 8:21 PM which revealed the blue left-hand splint remained in the box in a corner of Resident #39s room out of her reach.	F 688	exercises and wearing splints as ordered. There were no additional residents identified as having been adversely affected by the alleged deficient practice. Systemic Changes On 8/20/2021, the Staff Development Coordinator (SDC) started education for all licensed nursing staff and Certified Nursing Assistants with the following items included in the education. " Splints and range of motion exercises should be provided and documented as ordered " Nurses will ensure that splints and range of motion exercises are provided and documented as ordered " Any refusals or change in condition will be documented and reported to the supervising nurse. The SDC will complete education by 9/9/2021 and any licensed nursing staff and/or CNA out on leave or PRN status will be educated prior to returning to duty by the SDC. Newly hired licensed nursing staff and/or CNA□s will be educated during orientation by the SDC. Monitoring An audit tool was developed to monitor for compliance with the plan of correction. The following items are included in the audit. " Have the range of motion exercises been provided, and the splint been applied and removed as ordered? " Have the range of motion exercises and splint application been documented as ordered?	

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F 688	Continued From page 13 During an interview and observation with the Nurse Aide #2 (NA) on 08/19/21 at 9:30 AM she revealed she was not aware Resident #39 had an order for a left-hand splint. Observation of the NA charting did not have splinting identified. NA #2 stated it did not show up on the NA charting for Resident #39 to have a splint applied. Interview with the Nurse #4 on 8/19/2021 at 10:00 AM revealed Resident #39 had some left-hand tightness. The nurse reported that staff should encourage Resident #39 to wear the hand splint. The nurse further stated Resident #39 did not like to wear the splint. The therapy department had not been notified of Resident #39's refusal to wear the splint. Nurse #4 stated she had not documented Resident #39's refusal to wear her splint. During an interview with the Therapy Director on 8/19/2021 at 10:30 AM, he revealed staff were to encourage Resident #39 to wear the splint and to check her skin integrity. He further revealed if the resident refused to wear the splint, the therapy department should have been notified so the resident could be reassessed. When Resident #39 was last assessed she was able to independently apply her splint although staff should have encouraged and provided her with the splint. An interview with the Director of Nursing (DON) on 8/20/2021 at 2:17 PM revealed Resident #39 was alert and oriented and nursing would not necessarily have notified the therapy department if she refused to wear the splint. The DON further stated if Resident #39 refused to wear the splint it should have been documented.	F 688	" Have refusals or changes in condition been documented and reported to the supervising nurse? The DON, RN Supervisor, and/or SDC will audit 20% of all residents with doctor orders for splints and ROM exercises weekly for 4 weeks, then biweekly for 4 weeks, then monthly x 1 month. The results of these audits will determine the need for further monitoring. QAPI To ensure continued compliance and solutions are sustained, the DON will bring the audit results to Quality Assurance and Performance Improvement Committee monthly for review and further recommendations.	

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F 688	Continued From page 14 Follow up interview completed with Resident #39 on 8/20/2021 at 2:55 PM. Resident #39 revealed she had not refused to wear her splint and further stated if staff had offered the splint, she would have worn it. An interview with the Administrator on 8/20/2021 at 3:20 PM revealed Resident #39 could not put the left-hand splint on without assistance and the resident should not have had to request the hand splint. He further stated if Resident #39 refused to wear the hand splint, the appropriate staff should have been notified.	F 688		
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	F 761		9/9/21

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F 761	Continued From page 15 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, staff and pharmacist interviews, the facility failed to discard expired medications in 2 of 3 medication carts (600 Hall and 700 Hall) and failed to ensure the medication storage room was locked for 1 of 1 medication storage rooms (600 Hall) reviewed for medication storage. The findings included: Manufacturer's guidelines for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution revealed: Unit dose must remain within foil pouch at all times and once exposed, use individual vials within 2 weeks, protect from light. 1 a. An observation of the 700 Hall medication cart was completed on 08/19/21 at 11:51 AM and revealed the following regarding Ipratropium Bromide medications: 1 box opened on 07/17/21- 23 vials exposed 1 box opened on 07/24/21- 16 vials exposed 1 box opened on 07/15/21- 26 vials exposed 1 box opened on 08/01/21- 28 vials exposed 1 box opened on 04/01/21- 9 vials exposed An interview was completed with Nurse #3 on 08/19/21 at 11:51 AM. Nurse #3 verbalized Nurse #2 checked the medication carts for expiration dates weekly on Tuesdays. Nurse #3 did not	F 761	F 761 Affected Resident The opened, exposed, undated and expired medications from the 600 and 700 hall medication carts were immediately removed and discarded by the Director of Nursing on 8/20/21. The Maintenance Director adjusted the medication room door on the 600 hall to close faster and latch shut in lock position on 8/19/2021. No resident was affected by the alleged deficient practice. Residents with potential to be affected All residents in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON), Registered Nurse (RN) Supervisor and Staff Development Coordinator (SDC) checked all medication carts in the facility to ensure that there were no opened and undated, exposed and/or expired medications in the medication cart on 08/20/2021. No additional opened, undated, exposed or expired medications were observed in any cart in the facility. The Maintenance Director checked the other medication room on 8/20/2021 to ensure that the door closed and latched shut in locked position. The door closed and latched in the locked position. No resident was affected by the alleged deficient practice.	

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F 761	Continued From page 16 indicate that she checked the medication cart at the start of her shift. Nurse #3 was not aware of how long the medication was good for after the foil packaging was opened. Nurse #3 was shown the manufacturer's guidelines and agreed the vials should be discarded. b. An observation of the 600 Hall medication cart was completed on 08/20/21 at 01:45 PM and revealed the following regarding Ipratropium Bromide medications: 1 box opened on 07/19/21- 4 vials exposed 1 box no open date- 25 vials exposed An interview with Nurse #4 on 08/20/21 at 01:45 PM revealed she wrote open dates on medication boxes when she opened them. Nurse #4 communicated she went by the expiration date on the box for the Ipratropium Bromide medication and checked for expiration dates when medications were administered. Nurse #4 was not aware of how long the medication was good for after the foil packaging was opened. Nurse #4 verbalized Nurse #2 checked the medication carts for expiration dates on Tuesdays. Nurse #4 expressed she would pull the sticker labels and reorder the medication. The pharmacy medication audits form titled "Med Cart Inspection (Pharmacist)" dated 08/11/21 did not list Ipratropium Bromide on the expired medications portion of the form. A reminder was placed on the form to "please check open dates and expiration dates weekly." An interview was conducted with the facility Pharmacist on 08/20/21 at 01:28 PM. She was familiar with the manufacturer's instructions for	F 761	Systemic Changes All licensed nurses will be educated on policy regarding proper labeling and storage of drugs and biologicals by the SDC, DON and/or their designee. All licensed nursing staff will also be educated by the SDC/DON and/or their designee to ensure that medication room door remains in locked position when exiting the medication storage room. In addition, a list of medications with shortened expiration dates is also located on all medication carts for reference. This education will be completed by 9/9/2021. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the Staff Development Coordinator. Newly hired licensed nursing staff will be educated during orientation by the Staff Development Coordinator. Monitoring An audit tool was developed to ensure compliance with the plan of correction. The audit tool contains the following: 1. Are there any expired medications on the medication carts? 2. Are there any opened, undated medications on the medication carts? 3. Are opened Ipratropium Bromide and Albuterol Sulfate inhalation solutions removed from cart 2 weeks after opening? 4. Are medication room doors locked? Starting 9/9/2021 the Director of Nursing or RN Supervisor will audit 100% of all medication carts and medication storage rooms weekly x 4 weeks, then biweekly x	

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F 761	Continued From page 17 Ipratropium bromide and indicated the medication was considered expired in 2 weeks once the box and foil were opened. An interview with the Unit Manager conducted on 08/20/21 at 01:31 PM revealed the pharmacy checked medication carts monthly for expired medications. She further indicated a nurse checked the medication carts weekly for expired medications. After reading the manufacturer's guidelines, the Unit Manager indicated the vials should be discarded. An interview was attempted with Nurse #2 on 08/20/21 at 03:16 PM with no success. An interview with the Director of Nursing (DON) on 08/20/21 at 02:17 PM revealed expired medications should not be in the medication carts. The DON expressed nurses should be looking at expiration dates while completing their medication administration. She further indicated pharmacy checked the medication carts monthly for expired medications and Nurse #2 checked the medication carts weekly for expired medications. 2. On 08/19/21 from 08:52 AM until 08:55 AM a continuous observation was completed of the medication storage room on 600 Hall. The observation revealed the door handle to the medication storage room was in the locked position, but the door was not shut. Therefore, the door was not latched and was able to be pushed open. No facility staff or residents were observed in the medication storage room. A sign on the door read "Notice: This room must remain locked at all times." At 08:55 AM a nurse went into the medication storage room. She had a key in her	F 761	4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. QAPI All audit information will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly by Director of Nursing to be analyzed and reviewed for further recommendations.	

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F 761	Continued From page 18 hand to unlock the door but realized the door was not latched and a key was not needed. She returned from the medication storage room, pulled the door closed and checked the locked handle. An interview was conducted on 08/19/21 at 11:11 AM with the Unit Manager. She stated the door to the medication storage room should not be left open and nurses need to make sure the door is secured when they leave the room. The Unit Manager indicated only nurses have access to the medication storage room. An interview was conducted with the Director of Nursing on 08/20/21 at 10:41 AM. She indicated the medication storage room door should be closed and locked. On 08/20/21 at 03:50 PM an interview was conducted with the Administrator. He indicated the medication storage room should be locked at all times and he was unaware of the door not shutting before.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		9/9/21

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F 806	Continued From page 19 by: Based on observations, record review, resident and staff interview the facility failed to honor food preferences for 1 of 1 resident reviewed for food preferences (Resident #61). The findings included: Resident #61 was admitted to the facility on 7/20/2021. The admission Minimum Data Set (MDS)assessment dated 7/20/2021 indicated Resident #61 was cognitively intact, had no weight loss, and was on a 2 gram no salt diet. Review of care plan dated 7/27/2021 revealed Resident #61 had potential for weight loss related to COVID 19 visitation restrictions and decreased ability to obtain food from outside the facility. The goal stated Resident #61 would not exhibit signs of malnutrition or weight loss. The approaches included Resident #61 would receive help planning foods that would have a stimulating effect on her appetite based on her food preferences and offer substitutes if resident had problems with the food being served. Review of grievance form dated 8/9/2021 revealed Resident #61 complained of not receiving food preferences that were requested. The grievance further revealed Inservice conducted regarding customer service and food preferences were updated. During an interview on 8/17/2021 at 2:03 PM Resident #61 stated she was not getting scrambled eggs at breakfast. Resident #61 indicated this had happened for several days	F 806	F 806 Resident affected Resident #61 had food preferences updated 8/24/2021 by the Dietary Manager. On 8/24/2021 Dietary Cooks and Dietary Aides were in-serviced by Dietary Manager on resident food preferences and food tray delivery accuracy for resident for resident #61. There were no adverse effects to resident from alleged deficient practice. Residents with the potential to be affected An audit of facility resident food preferences was started by the Dietary Manager and Assistant Dietary Manager on 8/24/2021 and was completed by 9/8/2021 with any resident food preference request being updated on their Food Card. No additional residents were identified as having been adversely affected by the alleged deficient practice. Systemic Changes Dietary staff were educated on 8/24/2021 by the Dietary Manager on the following items. 1. Residents are allowed food preferences within the resident□s medical guidelines. 2. Where to find resident food preferences on the resident meal card. 3. Process for providing food preferences. 4. Residents can change their food preferences. 5. Process for staff to document changes to resident food preferences.	

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F 806	Continued From page 20 since she was admitted to the facility. Reviewed Resident #61 dietary profile dated 8/18/2021 which revealed Resident #61 had a special request for scrambled eggs, grits and toast every day for breakfast. During an observation and interview on 8/18/2021 at 8:15 AM Resident #61 had a meal ticket dated 8/11/2021 that stated scrambled eggs, grits, toast, margarine, jelly, water, juice and coffee. Scrambled eggs were not observed on Resident #61 meal tray. Further observation revealed Resident #61 meal to consist of pancakes. Resident #61 stated she normally got pancakes although she requested eggs. Interview conducted on 8/18/2021 at 4:06PM with the Social Worker (SW) revealed she had filed a grievance on 8/9/2021 related to Resident #61 food preferences. The SW stated she printed a copy of Resident #61 likes/dislikes and gave to dietary. She further stated she had given a copy of the grievance to the facility dietary manager. During an observation and interview dated 8/19/2021 at 8:05AM Resident #61 had a meal ticket that stated scrambled eggs, grits, toast, jelly, margarine, water, juice and coffee. Toast not observed on Resident #61 meal tray. Resident #61 stated she did not receive her toast this morning. An interview was conducted on 8/19/2021 at 8:34 AM with Nursing Aide #1 (NA). NA #1 stated the NA assigned to the hall would ask each resident her food preferences for breakfast and lunch and turn preference sheets into dietary. An interview conducted on 8/20/2021 at 1:52 PM	F 806	6. Ensure meal tray reflects items on food card. Any dietary staff out on leave or PRN status will be educated by the Dietary Manager prior to them returning to duty. Newly hired dietary staff will be educated during orientation by the Dietary Manager. Monitoring An audit tool was developed to monitor for compliance with the plan of correction. The audit contains the following: 1. Are food preferences documented on the food preference card? 2. Has the resident received their food preference as indicated on their food preference card? 3. Does the meal tray reflect the items on the food card? The Dietary Manager and/or Administrator will randomly audit 5 residents twice a week for four weeks, then 5 residents once a week for 2 months. The results of the audits will determine the need for further monitoring. QAPI All audit information will be brought to the Quality Assurance and Performance Improvement Committee meeting monthly by the Dietary Manager to be analyzed and reviewed for further recommendations.	

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F 806	Continued From page 21	F 806		

with Regional Dietary Manager (DM) and Dietary manager in Training revealed the DM was responsible for capturing likes and dislikes upon admission and completed resident food preference form. The DM or Nurse Aide (NA) would then review form with the resident. The NA asked each resident daily what their preferences were and utilize daily menus. The DM further indicated when a resident was due for quarterly MDS she updated the Resident Food Preference form. DM stated resident food preferences should be honored. DM revealed that when selecting the date to print the meal tickets, 8/11/21 was selected in error the correct date should had been 8/20/21. Pancakes were the meal served on 8/11/21 therefore the resident was served pancakes by mistake. DM stated however eggs were available every day and should have been made available for Resident #61 if resident had requested eggs. He stated dietary staff should be plating food according to the meal tickets. He further revealed the staff should be checking the meal tickets against the items on the resident's tray.

An interview conducted on 8/20/2021 at 2:53 PM the Director of Nursing (DON) revealed the facility would honor the resident's preferences. She stated staff should compare meal tickets with items on tray to ensure food preferences are met.

An interview conducted on 8/20/2021 at 3:37 PM with Administrator revealed the facility would honor the resident's food preferences.