STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

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E 000	Initial Comments An unannounced recertification survey was conducted on 8/23/21 through 8/27/21. The facility was found to be in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID QOK311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/23/21 through 8/27/21. Event ID QOK311. 1 of the 11 complaint allegations were substantiated resulting in a deficiency.	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 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	F 550		9/28/21

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

Electronically Signed | 09/17/2021

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F 550	Continued From page 1 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 record review, observations and staff interviews, the facility failed to maintain the dignity for 2 of 4 residents (Resident #112, #44) reviewed when the urinary collection bag was observed without a privacy covering and failed to promote dignity of 1 of 4 residents (Resident # 13) reviewed when Nurse Aide #1 was observed standing while assisting to feed the dependent resident a meal. Findings included: 1. Resident #112 was admitted to the facility on 2/16/21 and readmitted on 8/19/21 with a diagnosis of neuromuscular dysfunction of the bladder. The quarterly Minimum Data Set dated 7/30/21 revealed Resident #112 was cognitively intact.	F 550	Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on	

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F 550	Continued From page 2 He needed extensive assistance with mobility and transfers. He required total assistance with toilet use and was independent with eating. The MDS also revealed Resident #112 had an indwelling urinary catheter. A review of Resident #112's current care plan revealed a focus on altered pattern of urinary elimination with indwelling catheter. On 8/23/21 at 10:15 AM Resident #112's urinary catheter drainage bag was hanging on the side of the bed and could be seen from the hallway. The drainage bag had yellow urine in it and there was no privacy cover observed on the drainage bag. On 8/23/21 at 11:00 AM Resident #112's urinary catheter drainage bag was hanging on the side of the bed and could be seen from the hallway. The drainage bag had yellow urine in it and there was no privacy cover observed on the drainage bag. An interview was conducted with Resident #112 on 8/23/21 at 11:05 AM and he stated he didn't like for people to be able to see urine in his drainage bag. An interview was conducted with Nursing Aide #2 on 8/24/21 and 8:36 AM. She stated the facility had black bags the urinary drainage bags could be placed in so the urine would not be visible. She didn't know why Resident #112 didn't have one. On 08/24/2021 at 4:06 PM in an interview with the Director of Nursing, she stated the facility used privacy covers on urinary catheter bags, and urinary collection bags were to have a privacy cover.	F 550	this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights On 8/23/21, the Director of Nursing provided a privacy cover to the Foley drainage bag for resident # 112 and resident # 44. On 8/30/21, the Facility Nurse Consultant completed an audit of all residents with Foley catheters (Resident # 112 and resident #44 do not reside in the facility). This audit is to ensure all Foley drainage bags are covered with privacy covering to maintain resident dignity. There were no additional concerns identified. On 9/14/21, the Director of Nursing initiated 100% observation of all residents that requires assistance with meals to include resident # 13. This observation is to ensure staff are treating residents with dignity and respect by sitting when assisting residents with meals. The Administrative nurse will address all concerns identified during the audit to include education of staff. The audit will be completed by 9/28/21. On 9/6/21, the Director of Nursing initiated an in-service with all nurses and nursing assistants regarding Treating Residents with Dignity and Respect. Emphasis included dignity with meals and Foley catheter drainage bags covers to maintain	

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F 550	Continued From page 3 2. Resident #44 was admitted on 7/21/2021, and diagnoses included bladder outlet obstruction. The admission Minimum Data Set (MDS) assessment dated 7/28/2021 revealed Resident #44 was unable to complete the cognitive interview and was using a urinary catheter for elimination. Resident #44's care plan dated 8/03/2021 included a focus for an indwelling catheter. On 8/23/2021 at 10:44 a.m. Resident #44's door was open, and from the hallway, the urinary collection bag was observed facing the hallway with yellow urine and no privacy cover. On 8/24/2021 at 9:05 a.m. Resident #44's door was open, and from the hallway, the urinary collection bag was observed facing the hallway with yellow urine and no privacy cover. On 8/24/2021 at 3:56 p.m. in an interview with NA #2, she stated the urinary collection bag was positioned on the opposite side of the bed from the door to provide privacy and did not know why the urinary collection bag had been moved to the side of the bed facing the door. She further stated the facility had black bags to cover the urinary collection bag and could not recall Resident #44 having a black bag. On 08/24/2021 at 4:06 p.m. in an interview with the Director of Nursing, she stated the facility used privacy covers on urinary catheter bags, and Resident #44's urinary collection bag was to have	F 550	resident dignity. In-service will be completed by 9/28/21. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Treating Residents with Dignity and Respect. The Administrative nurse will audit all residents with Foley catheters weekly x 4 weeks then monthly x 1 month utilizing the Foley Audit Tool. This audit is to ensure all Foley drainage bags to include resident # 112 are covered with privacy covering to maintain resident dignity. The Administrative nurse will address all concerns identified during the audit to include providing a privacy covering when indicated and re-education of staff. The Administrative nurse will complete 5 meal observations for residents that require assistance with meals to include resident # 13 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audit Tool-Dignity Meals. This audit is to ensure staff are treating residents with dignity and respect by sitting when assisting residents with meals. The Administrative nurse will address all concerns identified during the audit to include re-education of staff. The Director of Nursing (DON) will review the Resident Care Audit Tool-Dignity Meals and the Foley Audit Tool weekly x 4 weeks then monthly x 1 month to ensue all concerns were addressed. The DON will present the findings of the Resident Care Audit Tool-Dignity Meals and the	

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F 550	Continued From page 4 a privacy cover. 3. Resident #13 was admitted on 4/5/2021, and diagnoses included malnutrition, dysphagia and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) assessment dated 7/6/2021 revealed Resident #13 was severely cognitively impaired, received a mechanical altered diet and required extensive assistance with eating. Resident #13's care plan dated 7/8/2021 included activities of daily living, and interventions included providing extensive physical assistance for eating and encouragement while remaining with the resident during meals. On 8/23/2021 at 1:20 p.m. Resident #13 was observed lying in the bed and his meal tray was observed sitting on the bedside table away from the bed. Nurse Aide #1 was observed entering the room and raising the bed as she prepared to assist to feed Resident #13. NA #1 was observed standing at the bedside while assisting to feed Resident #13 his meal. A chair was observed positioned at the foot of the bed in Resident #13's room. On 8/23/2021 at 1:28 p.m. in an interview with NA #1, she stated the height of the bed determined whether she sat or stood when assisting to feed Resident #13. She stated when sitting if too low, she would be reaching to feed Resident #13. She stated she knew she was to sit when feeding Resident #13 but standing while feeding Resident #13 was better for her than sitting.	F 550	Foley Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audit Tool-Meals and the Foley Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 550	Continued From page 5 On 8/24/2021 at 4:09 p.m. in an interview with Director of Nursing, she stated to provide dignity NA #1 should had been sitting at the resident's level when assisting to feed Resident #13.	F 550		
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 review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 33 residents whose MDS assessments were reviewed (Resident # 41 and #44.) The findings included: 1. Resident # 41 was admitted to the facility on 5/12/2021 with diagnosis that included chronic kidney disease, type II diabetes mellitus and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated 7/23/2021 did not indicate Resident # 41 had displayed any behaviors. Review of the nurse aide documentation during the look back period revealed the resident was yelling and screaming on 7/22/2021. During an interview on 8/26/2021 at 10:10 AM, the Director of Nursing reported the resident does exhibit behaviors and had displayed behaviors since he was admitted. During an interview 8/26/2021 at 2:50 PM the MDS nurse explained that Resident # 41 does exhibit behaviors including yelling and screaming. She confirmed that the coding of behaviors was inaccurate.	F 641	F641 Accuracy of Assessments On 8/26/21, The Minimum Data Set (MDS) nurse completed a significant correction to prior comprehensive assessment for Resident # 41, to reflect accurate coding for behaviors. On 8/24/21, The Minimum Data Set (MDS) nurse completed a significant correction to prior comprehensive assessment for Resident # 44, to reflect accurate coding for an indwelling catheter. On 8/31/21, the MDS Consultant initiated an audit of section E for all residents most current Minimum Data Set (MDS) assessment to ensure all MDS assessments completed are coded accurately for behaviors. The MDS nurse completed modifications for all concerns identified during the audit. Audit will be completed by 9/28/21. On 8/31/21, the MDS Consultant initiated	9/28/21

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F 641	Continued From page 6 During an interview the facility administrator on 8/26/2021 at 3:24 PM, she stated it was her expectation the MDS assessment be coded accurately. 2. Resident #44 was admitted on 7/21/2021, and diagnoses included bladder outlet obstruction from phimosis. A discharge summary dated 7/21/2021 from an acute care facility revealed Resident #44 had an indwelling urinary catheter upon discharge to the nursing home facility. The admission Minimum Data Set (MDS) assessment dated 7/28/2021 revealed Resident #44 was using an external urinary catheter for elimination. Resident #44's care plan dated 8/03/2021 included a focus for an indwelling catheter. On 8/24/2021 at 3:31 p.m. in an interview with the MDS Nurse, she stated there was nothing in the electronic medical record reflecting Resident #44 had an external urinary catheter, and she must have confused him with another resident. She stated the MDS for Resident #44 was incorrectly coded, and she would submit a modification of the MDS for Resident #13 for an indwelling catheter. On 8/24/2021 at 4:15 p.m. in an interview with the Director of Nursing, she stated Resident #44 had an indwelling catheter, and the MDS should have been coded for an indwelling catheter.	F 641	an audit of section H for all residents most current Minimum Data Set (MDS) assessment to ensure all MDS assessments completed are coded accurately for type of Foley. The MDS nurse completed modifications for all concerns identified during the audit. Audit will be completed by 9/28/21. On 9/14/21, the Nurse Consultant initiated an in-service with the MDS Coordinator, MDS Nurse, DON, and Administrator in regards to MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation regarding MDS Assessments and Coding. In-service will be completed by 9/28/21. 10% audit of all resident s most recent MDS assessments section E, and H will be completed by the MDS Consultant and/or Director of Nursing utilizing the MDS Accuracy Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment to include section E for behaviors and section H for residents with Foleys. The MDS Coordinator and DON will address all areas of concern identified during the audit to include retraining of the MDS nurse and completing necessary assessment of the resident. The Administrator will review and initial the	

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F 641	Continued From page 7 On 8/26/2021 at 5:05 p.m. in an interview with the Administrator, she stated the MDS needed to be accurately coded when completed.	F 641	MDS Accuracy Audit Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed. The DON will forward the results of MDS Accuracy Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MDS Accuracy Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to post "Oxygen in Use" safety signage for 1 of 1 resident (Resident #44) reviewed for oxygen use in a smoking facility. Findings included: The facility's, "Oxygen Therapy" policy dated April	F 695	F695 Respiratory/ Tracheostomy Care and Suctioning On 8/25/21, the Director of Nursing placed signage on resident # 44 door indicating oxygen in use. On 8/25/21, the Registered Nurse initiated an audit of all residents utilizing oxygen.	9/28/21

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F 695	Continued From page 8 2013 revealed "Oxygen in Use" signage was placed outside the rooms for residents receiving oxygen. Resident #44 was admitted to the facility on 7/21/2021. His diagnoses included COVID-19 and pneumonia. Resident #44's care plan dated 7/21/2021 included a focus for actual ineffective breathing related to COVID-19, and interventions included oxygen therapy at four liters per minute as physician ordered. The admission Minimum Data Safety (MDS) assessment dated 7/28/2021 revealed Resident #44 was receiving oxygen. On 8/23/2021 at 10:44 a.m., Resident #44 was observed receiving water humidified oxygen therapy, and there was no safety "Oxygen in Use" signage observed outside the room on the door. On 8/25/2021 at 10:41 a.m. in an interview with Nurse #1, she stated a sign stating oxygen was used in the room should be posted on Resident #44's door. On 8/25/2021 at 3:17 p.m. in an interview with the Director of Nursing, she stated smoking was allowed at the facility at designated times in a designated area, and signage stating "Oxygen in Use" was to be posted on Resident #44's door.	F 695	This audit is to ensure all residents to include resident # 44 utilizing oxygen have appropriate signage on the door indicating oxygen in use. The assigned nurse will address all concerns identified during the audit to include placing appropriate signage when indicated. Audit will be completed by 9/28/21. On 9/6/21, the Director of Nursing initiated an in-service with all nurses regarding Residents Utilizing Oxygen with emphasis on ensuring appropriate signage is placed on resident door indicating oxygen in use. In-service will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation regarding Residents Utilizing Oxygen. The Central Supply/Lead NA will monitor all residents to include resident # 44 utilizing oxygen weekly x 4 weeks then monthly x 1 month utilizing the Oxygen Audit Tool. This audit is to ensure all residents utilizing oxygen have appropriate signage on the door indicating oxygen in use. The Administrative Nurse will address all concerns identified during the audit to include placing appropriate signage when indicated and re-education of the nurse. The Administrator will review and initial the Oxygen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed. The DON will forward the results of Oxygen Audit Tool to the Executive Quality Assurance Performance Improvement	

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F 695	Continued From page 9	F 695	Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Oxygen Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		9/28/21

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F 758	Continued From page 10 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, pharmacist interview and physician interview, the facility failed to obtain a stop date for an as needed (prn) antipsychotic medication for 1 of 6 residents reviewed for unnecessary medications. (Resident #39) Findings included: Resident #39 was admitted to the facility on 7/6/2021. Her diagnoses included major depressive disorder. The physician orders dated 7/6/2021 revealed an order for Alprazolam, an antipsychotic medication, 0.25 milligrams (mg) every twenty-four hours as needed (prn) at bedtime for insomnia, and there was no stop date ordered for	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use On 8/26/21, the Director of Nursing clarified the stop date for the PRN antianxiety medication order for resident #39. The order was updated in the electronic record. On 9/14/21, the Director of Nursing initiated an audit of all PRN psychotropic medication orders. This audit is to ensure all PRN psychotropic orders have appropriate stop dates per pharmacy and facility guidelines. The assigned hall nurse will address all concerns identified during the audit to include clarifying orders with the physician as indicated to include stop dates. Audit will be completed by 9/28/21. On 9/14/21, the Director of Nursing	

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F 758	Continued From page 11 Alprazolam. A review of the physician progress notes dated 7/7/2021 revealed Resident #39 was very depressed, and to continue Alprazolam 0.25mg every night as needed for anxiety. The pharmacy ' s Admission Drug Regimen Review dated 7/8/2021 listed Alprazolam as a prn psychotropic medication without a stop date less or equal to fourteen days under medication considerations. There was no documented response from the physician on the Admission Drug Regimen Review. The admission Minimum Safety Data (MDS) assessment dated 7/13/2021 revealed Resident #39 was cognitively intact and received opioids, antianxiety and antidepressant medications. Resident #39 ' s care plan dated 7/16/2021 included the use of psychotropic drugs, and interventions included the evaluation of the effectiveness and side effects of medications for possible reduction and elimination of psychotropic drugs. The Medication Regimen Review(MMR) dated 7/23/2021 revealed the pharmacist requested the physician to document a rationale in Resident #39 ' s medical record and to indicate the duration of the prn order for Alprazolam if it was appropriate for the order to extend beyond fourteen days. There was no documented response from the physician on the MRR. A review of the physician progress notes dated 7/27/2021 to 8/31/2021 revealed no documentation of a rationale to extend the prn	F 758	initiated an in-service with all nurses in regards to PRN Psychotropic Medications with emphasis on ensuring medications have appropriate stop dates per pharmacy and facility protocol or physician documentation for continued use past the recommended stop orders. In-services will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation regarding PRN Psychotropic Medications. The Administrator nurse will review all newly written physician orders for PRN psychotropic medications to include orders for resident #39 utilizing the PRN Psychotropic Medication Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure all PRN psychotropic orders have appropriate stop dates per pharmacy and facility guidelines or physician documentation for continued use past the recommended stop orders. The assigned hall nurse will address all concerns identified during the audit to include clarifying orders with the physician as indicated to include stop dates. The DON will review the PRN Psychotropic Medication Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will forward the PRN Psychotropic Medication Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the PRN Psychotropic Medication Audit Tool to determine trends and / or issues that may	

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F 758	Continued From page 12 order for Alprazolam beyond fourteen days. On 8/26/2021 at 5:02 p.m. in an interview with the Director of Nursing (DON), she stated the MRR reports were returned to the pharmacy within thirty days. On 8/26/2021 at 5:09 p.m. in an interview with Pharmacist #1, he stated the DON distributed the MRR reports that addressed the Alprazolam order without stop date to the physician. He stated two MRR reports had been submitted, and neither of the two MMR reports had been returned to the pharmacy signed by the physician. He stated the pharmacy preferred physicians act on recommendations within a month. On 8/26/2021 at 5:13 p.m. in an interview with the Physician #1, she stated although Alprazolam helped Resident #39 sleep at night, she was receiving Alprazolam for anxiety and stated it was normally ordered for fourteen days as a prn medication. She stated the DON placed the MRR reports in a book for the physician to review. She stated she was at the facility twice a week and have not seen any recommendations for Resident #39. Physician #1 further stated she usually did not write fourteen day stop orders because the medication would not be available for Resident #39 if the medication was not reordered every fourteen days, and Alprazolam was not scheduled daily for Resident #39 due to concerns with drowsiness. On 8/26/2021 at 5:23 p.m. in a follow up interview with the DON, she stated she printed off the MMR reports from the pharmacy and placed the reports in the physician folders. She stated the physicians made adjustments and modifications to the	F 758	need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 758	Continued From page 13 resident ' s orders based on if they agreed with the recommendations.	F 758		
F 761 SS=D	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, staff interviews and record review, the facility failed to label an open vial of insulin on one of three medication carts (lower 200 hall medication cart) reviewed, and the facility failed to affix the locked narcotic box to the refrigerator in one of one medication rooms	F 761	F761 Label/Store Drugs and Biologicals On 8/25/21, the Director of Nursing removed all medication with incorrect labeling for date opened from the 200-hall medication cart.	9/28/21

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F 761	Continued From page 14 reviewed. Findings included: 1.On 8/24/2021 at 2:44 PM, the lower 200 hall medication cart was reviewed. A vial of long-acting insulin was removed from a plastic medication bottle with the date of 8/18/21 written in black marker on the label of the bottle. The vial of insulin had a label with the date marked 8/28 or 8/25. The nurse who was working on the hall stated she could not tell if it was 8/28 or 8/25, but either one was wrong, since the date on the vial should be when the vial was opened, and the date was 8/24/21. According to the manufacturer's recommendation, this long-acting insulin can be used for 28 days after opening. The Director of Nursing came to the cart and stated the vial should be discarded. 2. On 8/24/2021 at 3:39 PM, the facility's only medication storage room was reviewed with the Director of Nursing present. The refrigerator was unlocked and inside was a large metal box which was latched, not locked. Inside the box was a smaller, locked box. The Director of Nursing stated the locked box contained narcotics. Neither box was affixed to the refrigerator in any way. The Director of Nursing stated she understood the box was supposed to be affixed inside the refrigerator.	F 761	On 9/14/21, the Director of Nursing and Maintenance Director affixed the emergency narcotic kit to the medication room refrigerator. On 8/24/21, the Registered Nurse (RN) initiated an audit of all medication carts to include 200 hall. The audit is to ensure all medications to include insulin were dated appropriately when opened per facility protocol and manufacturer specifications. The RN will address all areas of concern identified during the audit to include removing and replacing all medications not dated appropriately when opened per facility protocol and manufacturer specifications and education of the nurse. The audit will be completed by 9/28/21. There are no other medication room refrigerators in the facility. On 9/14/21, an in-service was initiated by the Director of Nursing with all nurses in regards to Medications Storage with emphasis on all medications to include insulin were dated appropriately when opened per facility protocol and manufacture specifications and the requirements for affixing locked narcotic boxes. In-service will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation regarding Medications Storage. The Administrative nurses will audit of all medication carts to include 200 hall and the medication room refrigerator weekly x 4 weeks then monthly x 1 month utilizing	

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F 761	Continued From page 15	F 761	the Medication Audit Tool. This audit is to ensure all medications to include insulin were dated appropriately when opened per facility protocol and the narcotic box remains affixed in the medication room refrigerator. The Administrative nurses will address all concerns identified during the audit to include dating medications when opened per facility protocol, securing medications and re-education of the nurse. The DON will review and initial the Medication Audit Tool for completion and to ensure all areas of concerns were addressed weekly X 4 weeks then monthly X 1 month. The DON will forward the results of Medication Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Medication Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		9/28/21

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F 880	Continued From page 16 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 17 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of facility guidelines on Personal Protective Equipment (PPE), the facility failed to maintain infection control when two of three Nursing Assistants observed (Nursing Assistant #3 and #7) failed to don PPE to enter rooms as indicated on signage on quarantined resident ' s doors. This occurred during a COVID-19 pandemic. Findings included: A review of "Guidelines on Latest Approach to PPE Use During COVID-19 Pandemic" (updated June 2021), provided instruction for using PPE in each type of care unit. Listed for Quarantine Unit was: Due to the unknown status of residents in this unit, gowns should be changed between each patient and not reused or used in an extended manner. Gowns should be doffed prior to exiting	F 880	F880 Infection Control NA #3 is no longer employed at the facility On 8/23/21, NA # 7 was educated by the Director of Nursing regarding PPE on the quarantine unit. On 8/23/21, the Director of Nursing completed an audit of the quarantine unit to ensure that all current staff working on the unit that day were donning/doffing appropriate PPE to include gown, N95 mask, eye shield and gloves. There were no additional concerns identified. On 8/23/21, the Director of Nursing in collaboration with the Infection Preventionist initiated an in-service with all staff regarding required PPE in the	

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F 880	Continued From page 18 the patient ' s room and disposed of. Masks must be worn at all times and should be changed of soiled or when entering or leaving the unit. N95 masks are required on this unit. No masks other than N95s are permitted on this unit. Eye protection must be worn at all times and should be disinfected or replaced when entering or leaving the unit. At the end of the 100 hall there was a short hall of four rooms. Three of the rooms had doors closed and signs stating Enhanced Droplet Precautions were being observed. The signage stated PPE that must be worn and included gown, gloves, N95 mask, goggles or face shield, and the PPE must be removed when leaving the room and a new mask applied, and hands sanitized. On 8/23/2021 at 12:36 PM Nursing Assistant (NA) #3 was observed carrying a Styrofoam tray into a room on the quarantine hall. NA #3 was wearing a surgical mask and did not don PPE before entering the room. The Director of Nursing (DON) came to the door, called NA #3 out and told her she had to wear PPE. The DON left and NA #3 donned a gown and no other PPE, went into the room, and began to set up the lunch tray. She walked over to the boxed gloves on the wall inside the resident ' s room and donned gloves. NA #3 doffed the gloves and gown and left the room but did not change the mask. On 8/23/2021 at 3:30 PM NA #7 was observed standing in a room on the quarantine hall wearing an N95 mask and no other PPE. When she came out of the room and was asked why she did not don the required PPE, NA #7 stated she had been out, and she forgot. The room door remained open.	F 880	Quarantine Unit per facility protocol. Emphasis is on appropriate donning/doffing of PPE to include gown, N95 mask, eye shield and gloves per facility protocol. In-service will be completed by 9/28/21. All newly hired staff will be in-serviced during orientation in regards to PPE for Quarantine Unit. The Administrative team to include the Director of Nursing, Administrator and/or Infection Preventionist will observe 10 staff/resident care interactions weekly x 4 weeks then monthly x 1 month to include all shifts and weekends utilizing the PPE Quarantine Audit Tool. This audit is to ensure staff are utilizing appropriate PPE to include gown, N95 mask, eye shield and gloves per facility protocol in the Quarantine unit. The Infection Preventionist and Administrative nurses will address all areas of concern during the audit to include providing use of appropriate PPE and/or re-education of staff/residents. The DON will review and initial the PPE Quarantine Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the PPE Quarantine Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 month. The QAPI Committee will meet monthly x 2 months and review the PPE Quarantine Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of	

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F 880	Continued From page 19 In an interview on 8/26/2021 at 5:00 PM the DON stated there had been in-service a month prior to the survey.	F 880	monitoring.	