STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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E 000	Initial Comments An unannounced Recertification survey was conducted on 11/29/21 through 12/2/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TE2511.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 11/29/21 through 12/2/21. Event ID# TE2511.	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 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		12/10/21

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

Electronically Signed | 12/17/2021

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F 550	Continued From page 1 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 and staff interview the facility failed to cover a urinary catheter bag for 2 of 3 (Resident #87) residents reviewed for dignity. The findings included: Resident #87 was admitted to the facility om 6/11/19 with diagnoses that included urinary retention and diastolic congestive heart failure. Review of Resident #41's Annual Minimum Data Set (MDS) revealed he had moderate cognitive impairment, required extensive to total care with activities of daily living (ADLs) and an indwelling catheter. A review of Resident #87's care plan last revised 7/7/21 indicated he had an indwelling urinary catheter. The interventions included privacy cover for drainage bag to be always covered. A review of a physician's order dated 7/7/21 revealed an order for catheter privacy bag at all	F 550	F550 1-Resident #87's catheter bag was assessed on 12/1/21 at 4:20 PM by the DON and regional nurse. There was a cover observed on the bag. 2-An audit and observation of residents with indwelling urinary catheters was conducted on 12/3/21 by the DON. There were no other residents affected. Orders were reviewed by the DON/designee and updated as needed to include documentation of the urinary bag cover on the Treatment Administration Record every shift. This was completed on 12/13/2021. 3-Staff re-education was completed 12/3/2021-12/10/2021 to include urinary catheter bags to be covered. This education was added to the orientation education and the agency orientation packet. 4- All residents with urinary catheters will be observed/audited daily X 2 weeks,	

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F 550	Continued From page 2 times. An observation of Resident #87 was conducted on 12/1/21 at 11:08 AM. Resident #87 was laying in bed and his urinary drainage bag was visible with amber colored urine and no privacy bag was in place. An interview was conducted with Nursing Assistant #3 on 12/1/21 at 2:44 PM. NA #3 stated that Resident #87 should have had a privacy cover over his drainage bag. An interview was conducted with the Administrator on 12/2/21 at 5:04 PM. The Administrator stated he expected that urinary drainage bags would have a privacy cover at all times.	F 550	and then monthly X 3 to ensure bag covers are present. Re-education will be provided if concerns are observed. Audits will be reviewed in monthly QA. The QA committee will evaluate the need for further monitoring.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		12/10/21

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F 655	Continued From page 3 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview the facility failed to include a resident in the initial care planning for 1 of 5 newly admitted residents reviewed for initial care plans. (Resident #40). The findings included: Resident #40 was admitted to the facility on 10/8/21 and had a diagnosis of Stage IV pressure ulcer with osteomyelitis, diabetes mellitus and cerebrovascular accident (stroke).	F 655	F655 1-Resident #40's care plan was reviewed with him by the DON on 12/3/2021. 2-New admissions (residents) have the potential to be affected: Beginning 12/3/2021, residents who are cognitively intact will be invited to the admission care plan conference meeting. Re-education was provided to the SW and Admissions Director regarding residents being invited to the Admission Care Plan conference/72 hour care plan meeting.	

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F 655	Continued From page 4 The Admission Minimum Data Set (MDS) Assessment dated 10/17/21 revealed the resident was cognitively intact. On 11/29/21 at 2:30 PM an interview was conducted with Resident #40. The resident stated he was not aware of a care plan meeting since being admitted to the facility and had not received any information regarding his plan of care. On 12/01/21 at 3:20 PM an interview was conducted with Social Worker #1 regarding the initial care planning process. The Social Worker stated the Admissions Coordinator would call the family member and set up the initial care plan meeting with the family. The Social Worker was asked if alert and oriented residents were invited, and the Social Worker stated: "I would hope she would invite them." The Social Worker further stated she held the initial care plan meeting on the phone with a family member (on October 19, 2021) and the resident was not included in the care plan meeting. On 12/01/21 at 3:35 PM an interview was conducted with the Admissions Coordinator who stated that she called the family and set up a time for the initial care plan meeting, but the Social Worker would hold the meeting. Social Worker #1 joined the interview and stated she did not invite the resident or talk with him about his care plan. The Admissions Coordinator stated the initial Care Plan meeting was not held until October 19, 21 due to issues with setting up the meeting with the family. On 12/02/21 at 3:29 PM the Director of Nursing stated in an interview that the Admissions	F 655	The education included the admissions director is responsible for scheduling the meetings with the family and notifying the SW of the date and time. Once the information is received by the SW, the SW/designee is responsible for inviting the residents to the Admission Care Plan conference/72 hour care plan meeting. The education was provided on 12/2/2021 and 12/6/2021 by the Regional Clinical Director. 3-Audits will be conducted weekly by the Admission Director of residents' invitation/presence at the 72 hour care conference meeting to review the baseline care plan. These audits will be weekly for 6 weeks and then monthly for three months. 4- The results of the audits will be presented to the QA committee for further review and recommendations monthly for three months. The QA committee will evaluate the need for further monitoring.	

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F 655	Continued From page 5 Coordinator sends an invitation to the family and the Social Worker should invite the resident to the initial care plan meeting.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the care plan based on physician orders for 1 of 5 residents reviewed for	F 657	F657 1) Resident # 67's care plan was	12/10/21

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F 657	Continued From page 6 care plan (Resident #67). Findings included: Resident #67 was admitted to the facility on 09/05/19 with diagnoses that included dementia, congestive heart failure, and chronic obstructive pulmonary disease (COPD). Record review of the care plan dated 09/05/19 and revised on 09/07/21 revealed Resident #67 was a full code. Record review of the physician order dated 11/09/20 revealed Resident #67 had a Do Not Resuscitate (DNR) order. During an interview on 12/01/21 at 10:15 AM the Minimum Data Set (MDS) Nurse revealed that Social Service or nursing were responsible to revise the care plan when a code status change occurred. During an interview on 12/01/21 at 10:19 AM the Social Service Director revealed that she was responsible for the confirmation of code status and to revise the care plan. She was not able to state why the code status for Resident #67 was not revised to reflect the DNR order. During an interview on 12/02/21 at 9:45 AM the Director of Nursing (DON) revealed that Social Service or the MDS Nurse were responsible to revise Resident #67's care plan when the code status changed. During an interview on 12/02/21 at 2:27 PM the Administrator revealed that the clinical team led by the DON were responsible to revise the care	F 657	revised on 12/1/21 by the MDS nurse to reflect the correct code status 2) All residents have the potential to be affected. An audit was conducted on 12/3/2021 by DON/Designee to ensure all residents medical records had a code status. There were no negative findings. After the medical record audit, the social worker and MDS nurse audited all resident care plans to ensure code status was correct. Any discrepancies noted were corrected. This was completed on 12/6/2021 and 12/7/21. 3) Re-education was completed with the SW and the MDS department by the RCD on 12/6/2021. The re-education included care plan revisions to be completed in the morning clinical meeting when new admissions are reviewed and when orders are reviewed for changes in code status. 4) Weekly medical record/care plan audits of new admissions for code status accuracy will be conducted X 4 weeks by the MDS nurse and then monthly X 3 months. Audits will be reviewed in monthly QA. The QA committee will evaluate the need for further monitoring.	

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F 657	Continued From page 7 plan during the clinical meeting.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply a palm splint per the plan of care for 1 of 4 residents reviewed for position/mobility (Resident #25). The findings included: Resident #25 was admitted to the facility on 2/6/18 and had a diagnosis of cerebrovascular accident (stroke) with hemiplegia and hemiparesis (weakness and or paralysis of one side of the body) and contracture of the left hand. The Annual Minimum Data Set (MDS) Assessment dated 10/8/21 revealed the resident had severe cognitive impairment and required extensive to total assistance with activities of daily living (ADLs). The MDS noted the resident had impaired range of motion of the upper and lower extremity on one side of the body. The resident's current care plan noted the resident had impaired physical mobility and ADL	F 684	F684 1. The hand splints for Resident #25 was applied per physician order on 12/1/2021. 2. An audit of residents with splint orders was completed by the Rehab Program Manager on 12/1/2021 to ensure splints were applied as ordered. No issues were noted. 3. Splint orders were added to the medication administration record by the DON on 12/2/21. Re-education to Licensed Nurses and CNAs was completed from 12/2/21 to 12/10/21 by the Staff Development Coordinator/designee regarding applying hand splints as ordered. This education was added to the orientation education and the agency orientation packet. 4-Random weekly audits will be conducted by the DON/ Designee for 6 weeks and then monthly times 3 months to validate residents with hand splints have them applied as ordered. Any	12/10/21

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F 684	Continued From page 8 self-care deficit related to left sided hemiparesis. The intervention was to apply a palm splint to the left palm in the morning, to remove the splint for hygiene and remove the spline at the beginning of second shift. On 11/29/21 at 11:30 AM, Resident #25 was observed lying in bed and did not have a palm splint on the left hand and the hand was observed to be severely contracted. On 12/1/21 at 11:44 AM the resident was observed to receive wound care. There was not a palm splint for the left hand in place. On 12/1/21 at 2:45 PM The resident was observed lying in bed. There was not a palm splint in the resident's left hand. On 12/1/21 an interview was conducted with Occupational Therapist (OT) #1 who stated the Nursing Assistant (NA) on day shift was supposed to put on the splint after the bath and the NA was supposed to remove the splint at the beginning of the evening shift. The OT stated the purpose of the splint was to keep his fingernails from digging into the palm of the hand to prevent skin breakdown. On 12/1/21 at 4:10 PM an interview was conducted with NA #1 who stated she was assigned to Resident #25 on the day shift that day and was also staying over to work the evening shift. NA #1 was asked if the resident wore a palm splint and the NA stated she did not know. The NA was asked to look to see if there was a palm splint in the resident's room. The NA opened the resident's dresser drawer and removed a palm splint and stated she would put it	F 684	discrepancies will be immediately addressed. 4. Results of these audits will be presented during the centers QA & A Committee meetings monthly for 3 months by the DON/ designee. The QA & A Committee will review the audits and make recommendations based on outcomes. The QA & A Committee will determine the need for further	

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F 684	Continued From page 9 on the resident now. The NA was asked how she would know if a resident was to wear a splint and when the resident was supposed to wear the splint and she stated it would be on the resident's Kardex. The NA did not say why she did not apply the palm splint on the first shift. On 12/2/21 at 3:29 PM the Director of Nursing stated in an interview if the Kardex said the resident needed to wear a palm splint, then he needed to have the splint on per the plan of care.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		12/10/21

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F 690	Continued From page 10 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide complete incontinence care for 1 of 3 residents observed during incontinence care (Resident #25). The findings included: Resident #25 was admitted to the facility on 2/6/18 and had a diagnosis of cerebrovascular accident (stroke) with hemiplegia and hemiparesis (weakness/paralysis of one side of the body). The Annual Minimum Data Set (MDS) dated 10/8/21 revealed the resident had severe cognitive impairment, required total assistance with toileting and was incontinent of bowel and bladder. The current care plan for Resident #25 noted the resident had bowel and bladder incontinence. The interventions were to provide incontinence care every 2-3 hours and as needed and to provide peri-care after incontinent episodes. The care plan noted the resident used disposable briefs.	F 690	F690 1-Res #25 incontinence care was immediately provided by the treatment nurse when the surveyor indicated a possible issue. The treatment nurse was re-educated on proper incontinence care by the DON on 12/6/2021 with a competency demonstration. 2-There were no other identified residents. Incontinent residents have the potential to be affected. 3-Re-education was provided to clinical staff by the SDC/DON/nurse management designee on incontinent/perineal care. The need for perineal care to be completed when a resident is soiled/wet was part of the education. The re-education was conducted 12/6/21-12/10/21. This information will be added to the orientation education and to the agency orientation packet. 4-Random daily audits (observations) will be conducted X 2 weeks, weekly X 2 weeks and monthly X 3 months by the SDC/DON/Nurse management on incontinent/perineal care. Audits will be reviewed in monthly QA. The QA	

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F 690	Continued From page 11 On 12/1/21 at 11:44 AM the Treatment Nurse was observed to provide wound care for Resident #25. The Treatment Nurse removed the resident's brief and stated the resident was wet and had had a bowel movement. The Treatment Nurse was observed to use pre-moistened wipes to clean the resident's buttocks and peri-anal region to remove all the stool. The Treatment Nurse turned the resident onto his back and applied the brief and did not clean the resident in the front. The Treatment Nurse was asked if she normally cleaned a resident in the front to remove the urine from the skin when incontinent of urine and the Treatment Nurse stated she cleaned him from behind. The Treatment Nurse further stated with the resident's contractures she had to move him quickly and get the job done because it was painful to move him. On 12/2/21 at 3:29 PM an interview was conducted with the Director of Nursing who stated the Treatment Nurse should have cleaned the resident in the front.	F 690	committee will evaluate the need for further monitoring.	
F 695 SS=E	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, staff interviews, and	F 695	F695	12/10/21

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F 695	Continued From page 12 respiratory therapy interview the facility failed to provide tracheostomy care every shift to 1 of 1 resident reviewed for respiratory care (Resident #23). Findings included: Resident #23 was admitted to the facility on 7/30/20 with diagnoses that included chronic obstructive pulmonary disease (COPD) and tracheostomy (a surgical opening through the front of the neck into the windpipe with a tube placed to keep open for breathing). Record review of Resident #23 ' s care plan dated 7/31/20 revealed he was at risk for impaired gas exchange related to COPD and tracheostomy. Interventions included oxygen and suctioning as ordered, monitor for symptoms of respiratory distress, and respiratory therapy as needed. A physician order dated 9/16/20 for tracheostomy (trach) care every shift and as needed. A physician order dated 9/16/20 for trach collar change every evening shift. A physician order dated 9/16/20 for speaking valve (a valve placed on the outside opening of the tracheostomy to help with speaking clearly) to be removed at hour of sleep. The Annual Minimum Data Set (MDS) assessment dated 10/03/21 revealed Resident #23 was cognitively intact and required oxygen, suctioning, and tracheostomy care. Record review of the Treatment Administration Record (TAR) and Medication Administration	F 695	1-Res # 23's physician orders were updated in the Medical record on 12/2/2021 to include trach care every shift and PRN to be completed by the nurse. The information was added to the Medication Administration Record (MAR) on 12/2/2021. 2-No other residents in the facility were affected as there are no other residents in the facility with a tracheotomy 3-Staff re-education was provided by the SDC/Nurse/ designee starting 12/2/21 through 12/10/21 to nurses regarding q shift and PRN trach care and documentation of the assessment on the MAR. This education was added to the orientation education and the agency orientation packet. 4-DON/Clinical designee will review the order listing report and physician orders daily in the clinical meeting and check the medical record to ensure the orders were transferred to the MAR if needed. 5-Random weekly audits of physician orders will be conducted by the DON/designee X 6 weeks, then monthly X 3 months to ensure orders are transferred appropriately. Audits will be reviewed in monthly QA. The QA committee will evaluate the need for further monitoring.	

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F 695	Continued From page 13	F 695		

Record (MAR) dated November 2021 revealed the trach care every shift and as needed was not listed on the TAR.

Record review of the MAR dated November 2021 revealed that the trach collar was changed, and the speaking valve was removed every evening shift as ordered.

During an interview on 12/02/21 at 8:50 AM Nurse #1 revealed trach care was completed once a day and was scheduled to be completed on night shift when the speaking valve was removed. She stated that she would provide trach care and suction when needed but did not perform trach care to Resident #23 on every shift. Nurse #1 reviewed TAR and did not have trach care every shift order listed.

Record review of the tracheostomy care education log dated revealed Nurse #1 had completed the trach care education and was competent to provide the trach care for Resident #23.

During an interview on 12/02/21 at 8:55 AM the Director of Nursing (DON) stated that trach care was completed once a day. She stated that Resident #23 had trach care completed by the evening as ordered.

During an interview on 12/02/21 at 9:30 AM Resident #23 stated that his trach care was completed every night by the nurse. He stated that if he needed trach care during the day, he would tell the nurse.

During an interview on 12/02/21 at 10:00 AM Nurse #2, the evening shift nurse for Resident

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F 695	Continued From page 14 #23, revealed she completed trach care at night when the speaking valve was removed, and collar was changed. She stated that Resident #23 was able to verbalize if he needed additional trach care or suctioning. During an interview on 12/02/21 at 10:20 AM the Respiratory Therapist (RT) revealed trach care was completed once a shift and as needed. He stated that he provided respiratory education at the facility which included trach care. The RT stated that after the staff have completed the education, the nurse was competent to perform trach care. The RT reported that he made weekly respiratory rounds at the facility and Resident #23 did not report trach care was not completed on all shifts. Attempts to contact Nurse #3, Nurse #4, and Nurse #5, who were assigned to Resident #23 during the month of November, were not successful. During an interview on 12/02/21 at 10:40 AM the Staff Development Nurse revealed that nursing staff was educated that trach care was to be completed once a shift and as needed.	F 695		
F 758 SS=E	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;	F 758		12/10/21

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F 758	Continued From page 15 (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 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.	F 758		

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F 758	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, pharmacist interview, and physician assistant interview, the facility failed to review pharmacy consultant recommendations regarding psychotropic drugs with the physician for 3 of 6 residents reviewed for unnecessary medications (Resident #23, Resident #84, and Resident #77). The findings included: 1. Resident #77 was admitted to the facility on 9/4/2020 with diagnoses that included dementia, Parkinson's disease, and adult failure to thrive. The annual Minimum Data Set (MDS) dated for 10/16/2021 indicated Resident #77 was cognitively impaired. She had no behaviors or rejection of care. Resident #77 was not coded as receiving antianxiety medication during the assessment period. A physician's order dated for 9/23/2021 indicated Haloperidol (antianxiety medication) 1mg as needed every 6 hours for Resident #77. There was no stop date for this PRN Haloperidol order. A Pharmacy Consultation Report dated for 10/7/2021 indicated Resident #77 had a PRN Haloperidol order in place for greater than 14 days without a stop date. The recommendation was to discontinue the PRN order. Resident #77's current physician orders were reviewed on 12/1/2021 and the Haloperidol PRN order was still in place with no stop date. An interview was conducted with the Director of Nursing (DON) on 12/1/2021 at 2:50 pm. She	F 758	F758 Resident #77: The Haloperidal was discontinued on 12/1/21. Resident #23: The Lorazepam was addressed by the DON to the provider on 12/2/2021. The GDR was denied due to previous failed attempts. Resident #84: The Lorazepam order was addressed by the provider on 11/30/2021. -An audit was completed by the regional nurse of the residents with PRN psychotropics for appropriate stop dates on 12/7/21. There were no issues identified. -An audit of the last 2 months pharmacy recommendations was conducted by the DON and any recommendations not addressed were corrected by 12/13/2021. -Re-education was provided to the DON/Unit Managers on 12/3/21 by the regional nurse. The re-education included monitoring the PCC dashboard daily in the morning clinical meeting for 14 day stop dates on PRN psychotropics. This was added to the morning clinical meeting worksheet. The re-education included the policy/process for pharmacy recommendations, including the timeliness of physician review and signature. -The dashboard will be audited weekly by the DON/UM/designee for 14 day stop dates on PRN psychotropics. The pharmacy recommendations will be audited monthly by the DON/designee for physician signature and follow up. These audits will be weekly for 6 weeks and then	

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F 758	Continued From page 17 stated it was the Unit Manager's role to give the Pharmacy Consultation Reports to the Physician and/or PA each month and follow through with the Pharmacy Consultation Reports once they are signed. An interview was conducted with the Unit Manager on 12/2/2021 at 9:08 am. She indicated she did not handle the Pharmacy Consultation Reports. A telephone interview was conducted on 12/2/21 at 2:07 pm with the Consulting Pharmacist. He indicated after completing the facility's monthly pharmacy review, the Pharmacy Consultation Reports were emailed to the DON for her to have the facility Physician or PA review and sign. A telephone interview was conducted with the facility PA on 12/2/2021 at 3:01 pm. She indicated PRN psychotropic medications were ordered with a 14 day stop date and Resident was reevaluated for continued use. During an interview on 12/2/021 at 3:43 pm with the Administrator, he indicated it was his expectation that all PRN psychotropic medications have 14 stop date. 2. Resident #23 was admitted to the facility on 7/30/20 with diagnoses that included tracheostomy (a surgical opening through the front of the neck into the windpipe with a tube placed to keep open for breathing), depression, and anxiety. Record review of the care plan dated 7/31/20 and reviewed on 12/01/20, 7/16/21, and 11/11/21 revealed Resident #23 had a tracheostomy and	F 758	monthly for three months. 4- The results of the audits will be presented to the QA committee for further review and recommendations monthly for three months. The QA committee will evaluate the need for further monitoring.	

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required oxygen, suctioning, and tracheostomy care. Resident #23 had a care plan for antianxiety medications with interventions to monitor for signs and symptoms of anxiety and document occurrence of behavior symptoms.

Review of Resident #23 ' s medical record revealed a physician order dated 7/16/21 for Lorazepam (medication for anxiety) 0.5 milligram (mg) tablet three times a day.

The Annual Minimum Data Set (MDS) assessment dated 10/03/21 revealed Resident #23 was cognitively intact and required oxygen, suctioning, and tracheostomy care. Resident #23 was coded for anti-anxiety medication but was not coded for behaviors.

Record review of the Medication Administration Record (MAR) dated November 2021 revealed that Resident #23 did not exhibit behavior symptoms associated with anxiety.

Record review of Pharmacy Consultation Report dated 11/02/21 revealed a recommendation for the physician to consider a gradual dose reduction (GDR) of Lorazepam 0.5 mg to twice daily for Resident #23. The physician response line revealed the GDR was not implemented at this time due to failed GDR attempt, history of respiratory condition, and anxiety. The Consultation Report was signed by the Director of Nursing (DON) and dated 11/02/21. The physician signature line and the date were not completed.

Record review of physician progress note dated 11/03/21 indicated that the physician did not review the GDR request for Lorazepam or the

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decision to accept or deny the pharmacy recommendation.

During an interview on 12/02/21 at 2:07PM the pharmacist stated that the GDR recommendations were to be signed only by the physician, Nurse Practitioner, or Physician Assistant.

During an interview on 12/02/21 at 2:15 PM the DON revealed that she completed the form and signed the document. She stated she was aware the physician was required to review and complete the Pharmacy Consultation Report. She stated the doctor or physician assistant did not receive the Pharmacy Consultation Report. The DON stated that she was new to the facility and the facility did not have a process in place regarding the pharmacy recommendations.

During an interview on 12/02/21 at 3:01 PM the Physician Assistant (PA) revealed that she reviewed the pharmacy recommendations and she approved or denied them based on the individual resident clinical symptoms. She stated she normally reviewed the reports monthly. The PA stated that she would complete the form and document in her progress note that she had reviewed the GDR and approved or denied based on clinical findings.

3. Resident # 84 was admitted to the facility on 11/01/21 with diagnoses that included lung cancer and fracture of left femur (thigh bone).

Record review of Resident #84 ' s care plan dated 11/01/21 revealed he had impaired mobility, pain, and was on antianxiety medication.

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Review of Resident #84 ' s medical record revealed a physician order dated 11/01/21 for Lorazepam 0.5 mg tablet every 4 hours as needed for anxiety/agitation. The as needed (PRN) Lorazepam order did not have a stop date.

Record review of Pharmacy Consultation Report dated 11/05/21 revealed that Resident #84 had a PRN order for Lorazepam without a stop date. The recommendation was to provide a duration of therapy (stop date). The physician ' s response section was marked as accepted with free text of stop date added. The physician signature and date line were not completed.

The Quarterly Minimum Data Set (MDS) Assessment dated 11/10/21 revealed Resident #84 was cognitively impaired. Resident #84 was coded for anti-anxiety medication.

A physician order dated 11/30/21 for Lorazepam 0.5 mg tablet every 4 hours as needed (PRN) for anxiety/agitation for 14 days.

During an interview on 12/02/21 at 2:07 PM the pharmacist revealed that the consultation reports were emailed to the Director of Nursing (DON) after the review was completed. He stated that the DON should have given the reports to the appropriate physician for review.

During an interview on 12/02/21 at 2:13 PM the DON revealed that she documented on the Consultation Report stop date added and entered a new physician order on 11/30/21 for the Lorazepam with a stop date of 14 days. She stated the facility did not have a process in place for who was responsible for monitoring pharmacy recommendations. The DON reported the

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F 758	Continued From page 21 physician orders were reviewed during the clinical meeting but was unable to say why the Lorazepam PRN order without a stop date for Resident #84 was missed. During an interview on 12/02/21 at 2:39 PM the Administrator revealed the physician orders were reviewed during the clinical meeting and were expected to be corrected at the time they were reviewed. During an interview on 12/02/21 at 3:01 PM the Physician Assistant (PA) revealed that psychotropic medication (including anti-anxiety medication) that were ordered PRN were required to have a 14 day stop date. She stated that after 14 days the PRN medication would be re-evaluated and if needed the medication would be extended.	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.	F 761		12/10/21

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F 761	Continued From page 22 §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 observation, record review and staff interviews, the facility failed to monitor and report out of range temperatures for 1 of 1 medication refrigerator (main medication room refrigerator), the facility failed to dispose of expired medication for 2 of 3 medication carts (Lower South Hall, North Hall), and failed to date opened medications for 1 of 3 medication carts reviewed for medication storage. (Lower South Hall) The findings included: 1a. Review of the facility's policy for storage of refrigerated medications dated 5/2020 revealed the temperatures of all refrigerators containing medications were to be maintained between 36 degrees and 46 degrees Fahrenheit. An observation was conducted of the medication storage room on 11/30/21 at 3:47 PM with Nurse #3 present. Review of the temperature chart for the month of October revealed the temperature had not been recorded on 10/11, 10/18, 10/19, 10/20, 10/25, 10/26, 10/27, 10/28 and review of the temperature chart for the month of November revealed the temperature had not been recorded on 11/1, 11/6, 11/7, 11/25. On 11/14 the refrigerator temperature was documented to be at	F 761	F761 1-No identified affected residents 2-All residents have the potential to be affected. The facility medication carts were inspected for expired medications on 12/3/2021 by the DON/Unit managers. Concerns observed were addressed immediately. The refrigerator temp logs were reviewed on 12/3/21 by the DON with no concerns observed. 3-Nursing re-education was provided 12/6/2021-12/10/2021, the re-education included medication cart audits 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. The re-education included the refrigerator temperature log completion by the Unit Manager/Designee every morning and following the directions on the log if any temperature is out of range. 4-Medication cart and medication storage rooms including the refrigerator temps will be checked by the DON/UM/designee every Thursday. DON/UM/designee will	

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F 761	Continued From page 23 28 degrees Fahrenheit, 11/19 the refrigerator temperature was documented at 30 degrees Fahrenheit, 11/20 the refrigerator temperature was documented at 30 degrees Fahrenheit and 11/21 the refrigerator temperature was documented at 30 degrees Fahrenheit. An interview was conducted with Nurse #3 on 11/30/21 at 4:03 PM. Nurse #3 stated the night shift nurse was responsible for checking the refrigerator and making sure that the temperature was logged. An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 4:05 PM. the DON stated that the Unit Managers were responsible for checking the refrigerator temperatures b. An observation was conducted on 12/2/21 at 10:00 AM of the medication cart labeled as Lower South unit cart with Nurse #3 present. The Lower South unit cart revealed the following medications that were available for use: 1 bottle of Olopatadine HCL Ophthalmic Solution with an expiration date of 8/24/21. 1 bottle of Olopatadine HCL Ophthalmic Solution with an expiration date of 8/15/21. 1 bottle of opened Lumigan 0.01% Ophthalmic Solution with no open and no expiration date. An interview was conducted with Nurse #4 on 12/2/21 at 10:05 AM. Nurse #4 stated that eye medications were to be dated when opened and discarded 28 days after being opened. Nurse #4 stated that the nurse working the cart was responsible for checking for expired medications. Nurse #4 stated the expired medications were to be discarded.	F 761	perform a medication cart audit weekly X 4 weeks, then monthly X 3 months. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 24 An interview was conducted with the Director of Nursing (DON) on 12/2/21 at 10:30 AM. The DON stated that eye medications were to be labeled when opened and discarded 30 days from the open date. The DON stated that expired medications were to be removed from the medication carts and discarded. c. An observation was conducted on 12/2/21 at 10:13 AM of the North Hall medication cart with Nurse #5 present. The North Hall medication cart revealed the following medication that was available for use: 1 bottle of Liquid Pain Relief 160mg/5ml with an expiration date of 11/21. An interview was conducted with Nurse #5 on 12/2/21 at 10:18 AM. Nurse #5 stated that the nurse working the cart was responsible for discarding expired medications. Nurse #5 stated she did not realize that the medication was expired. An interview was conducted with the DON on 12/2/21 at 10:30 AM. The DON stated that expired medications were to be removed from the medication carts and discarded.	F 761		