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	345419	A. BUILDING _____ B. WING _____	C 01/10/2022

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LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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E 000	Initial Comments The survey team entered the facility on 12/28/21 to conduct a recertification and complaint investigation survey from 12/28/2022-12/30/2022. Additional information was obtained offsite and the survey team returned to the facility on 1/4/2022 and 1/5/2022. Additional information was obtained offsite 1/6/2022 and 1/7/2022. The survey team returned to the facility on 1/10/202 and completed the survey on 1/10/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SDTD11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 12/28/21 to conduct a recertification and complaint investigation survey from 12/28/2022-12/30/2022. Additional information was obtained offsite and the survey team returned to the facility on 1/4/2022 and 1/5/2022. Additional information was obtained offsite 1/6/2022 and 1/7/2022. The survey team returned to the facility on 1/10/2022 and completed the survey on 1/10/2022. Event ID #SDTD11 Three of the 21 complaint allegations were substantiated and resulted in deficient practice at F 624, F 755, and F 559. During the survey, immediate jeopardy was identified at CFR 483.15 at F 624 at a scope and severity (J). Immediate Jeopardy tag F624 began on 12/13/2021 and was removed on 1/7/2022.	F 000		
F 624 SS=J	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge.	F 624		2/14/22

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

Electronically Signed | 02/03/2022

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F 624	Continued From page 1 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician, home health, resident, and resident family interviews, the facility failed to provide for a safe discharge to meet the needs of 1 of 3 residents who lived alone, was incontinent, had a pressure ulcer, was dependent on oxygen, and had physical limitations, (Resident #290). Immediate Jeopardy began on 12/13/2021 when Resident #290 was discharged to home to ascend 19 steps with oxygen to home where she lived alone, was incontinent, without home health services, without medical equipment, without instructions for wound care, without wound care supplies, and without a home assessment being completed. Immediate Jeopardy was removed on 1/7/2022 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. Findings included: Resident #290 was admitted to the facility on 11/16/2021 with diagnoses to include viral	F 624	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F624 Identify those recipients who have suffered a serious adverse outcome as a result of the noncompliance Deficient practice occurred on 12-13-21 when resident #290 was discharged home without a safe and appropriate discharge plan in place. Resident #290 no longer a patient at the facility. Identify those recipients who have the potential to be affected by the same deficient practice All residents that discharged from Lexington Health Care Center after	

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F 624	Continued From page 2 pneumonia, Chronic Obstructive Lung Disease (COPD), Stage 3 pressure ulcer, and COVID-19. A physician order dated 11/18/2021 ordered oxygen for Resident #290 at 2-6 liters per minute continuously. The admission Minimum Data Set (MDS) assessment dated 11/22/2021 assessed Resident #290 to be cognitively intact. The MDS assessed Resident #290 to require extensive assistance dressing, toileting, hygiene, and bathing. The MDS documented Resident #290 was frequently incontinent of bladder and bowels. The MDS documented Resident #290 had 2 Stage 3 pressure ulcers. The MDS documented Resident #290 received oxygen therapy and had dyspnea (shortness of breath with activity). Nursing assistant (NA) #3 was interviewed on 12/30/2021 at 9:36 AM. NA #3 reported she provided care to Resident #290 frequently during her stay at the facility. NA #3 reported Resident #290 became very short of breath with all activity, even with the oxygen on, and Resident #290 required rest breaks. NA #3 reported Resident #290 was able to transfer to the wheelchair from bed with 1-person assistance, required at least 1 person assistance to position in bed, and she needed 1-person assistance with all toileting tasks. An interview was conducted with NA #4 on 12/30/2021 at 9:57 AM. NA #4 reported Resident #290 was extremely short of breath with all activity, and she needed to stop to rest during any activity. NA #4 reported Resident #290 had been attempting to become more independent with toileting but required 1-person assistance to	F 624	12-13-21 to home were reviewed by the corporate discharge planning specialist. No concerns identified. Identify measures that have been put in place to ensure that deficient practice will not recur for future discharges to home Corporate Discharge Planning Specialist audited the 17 discharges that occurred between the dates of 12/13/21 and 01/07/22. Audits revealed no further unsafe discharge planning concerns. For discharges without adequate documentation related to discharge, discharge planner, made calls to the discharged resident and/or responsible parties to ensure services were received as ordered and entered progress notes into patient□s medical records. Discharge planner will be educated on Discharge planning role in skilled/transitional care by the administrator and Corporate discharge planning specialist on 01/06/2021 to ensure a safe and appropriate discharge plan The discharge planner specifically will be educated to complete the following tasks, as per policy: 1. Within 24 hours of admission or first business day if on weekend discharge planner will confirm patient/responsible party plans and support 2. Discharge Planner will identify post discharge needs with the interdisciplinary team daily in morning patient review meetings 3. Keep interdisciplinary disciplinary team informed of discharge planning initiatives	

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F 624	Continued From page 3 transfer and perform hygiene. NA #5 was interviewed on 12/30/2021 at 10:14 AM. NA #5 reported Resident #290 was very short of breath with all activity. NA #5 reported Resident #290 required assistance to transfer from the bed to the wheelchair and with all toileting tasks. A social work/discharge planning progress note dated 11/23/2021 was reviewed. The note documented a discussion with Resident #290 regarding her discharge planned for home. The note documented Resident #290 reported her family member assisted with shopping and was able to assist with household chores. The note documented Resident #290 lived on the 2nd floor of her building and her family member was working on getting her a ground-level apartment. Resident #290 reported it was her plan to return home and did not want to consider an alternative plan. The note documented Resident #290 had applied for Medicaid, but she did not qualify. The note documented Resident #290 had oxygen in her home but may need a wheelchair upon return to home. The wound care consult note dated 12/08/21 indicated Resident #290 ' s bilateral buttocks wound was a Stage 3 with scant serous (clear to light yellow) exudate (drainage) and measured 4 centimeters (cm) by 3.5cm by 0.5 cm. Review of the treatment orders for Resident #290 ' s pressure ulcer revealed an order dated 12/9/2021 to cleanse the wound to the buttocks with wound cleanser, apply honey fiber dressing to the wound bed (an absorbent gel dressing to promote healing) and cover with a non-stick	F 624	4. Assist with, apply for, and/or secure needed services post discharge to include DME, Personal Care, and home health services. 5. Finalize and confirm services prior to discharge 6. Communicate all discharge plans with the patient, RP, and/or interested parties If at any time the discharge planner has any question of safety during the discharge process, discharge planner will discuss with the IDT team immediately to form a resolution in order to ensure a safe and appropriate discharge. Education specifically provided to Discharge Planner a by the Corporate discharge planning specialist on 01/06/2021 outlining requirements of the planning role in skilled/transitional care to ensure a safe and appropriate discharge plan. The Interdisciplinary team also educated on 1-6-22 by the VP of Operations and Corporate Discharge Planning Specialist on the policy regarding discharge planning. Education included requirements of communication to bring potential barriers to discharge to the attention of the discharge planner and other members of the team, in order to address these barriers prior to discharge. The interdisciplinary team consists of Administrator, Director of Nursing, MD/Medical Provider, nurse manager, Director of Rehab, Discharge planner/social worker, and Dietary Manager. Monitoring the discharge process to ensure that the plan of correction is effective and that specific solutions are	

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F 624	Continued From page 4 transparent dressing and gauze. This wound care was to be performed daily. Review of the physician discharge summary for Resident #290 dated 12/13/2021 noted referrals for a home health nurse, Physical Therapy, and Occupational Therapy for strengthening and a Social Worker for community resources. The discharge summary did not include any information related to the pressure ulcer or wound care. A physical therapy discharge assessment completed on 12/13/2021 documented Resident #290 required partial to moderate assistance to ascend/descend 1 step, substantial to maximum assistant to ascend/descend 4 steps and was totally dependent for 12 or more steps. The physical therapy discharge note documented Resident #290 required substantial to maximum assistance for ambulation of 150 feet. The physical therapy discharge note recommended 24-hour care and an assistive device for safe and functional mobility for Resident #290 when she returned home. An interview was conducted with the physical therapist (PT) on 1/5/2022 at 9:50 AM. The PT reported Resident #290 was unable to ascend stairs due to shortness of breath and fatigue, and she was unable to lift her body weight from one stair to the next and required extensive to total assistance. The PT reported Resident #290 required assistance to lift approximately 50% of her body weight up when ascending stairs due to fatigue, dyspnea, and poor endurance. The PT reported Resident #290 required 1-2.5 minutes of recovery after activity related to shortness of breath. The PT reported Resident #290 required	F 624	sustained All discharges will be reviewed for 4 weeks by the corporate discharge planner to ensure a safe and appropriate discharge. 50% of all discharges will be reviewed thereafter for a period of 8 weeks. Finally, 10% of discharges will be reviewed for a period of two months. Results will be reviewed during quarterly QAPI meetings. Date of compliance is 2-14-22 The Administrator is responsible for implementing the acceptable plan of correction	

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oxygen, and even with oxygen, her saturation levels were low. The PT reported a home visit had not been completed because Resident #290 was unable to perform stair climbing and she would have failed the home visit. The rehab therapy manager was interviewed at the same time and she reported it was the therapy department ' s opinion that Resident #290 was not safe to discharge, but they thought she was going to her family member ' s home without stairs, and she was going to receive home health therapy. The rehab therapy manager reported Resident #290 ' s limitations had been discussed with the interdisciplinary team in the daily morning meetings and the discharge planner/social worker (SW) had been a participant in those meetings.

The discharge MDS dated 12/13/2021 documented Resident #290 was cognitively intact, required extensive assistance with bed mobility, dressing, and toileting, and was frequently incontinent of bladder and bowels. The discharge MDS documented Resident #290 was short of breath with exertion, at rest, and when lying flat. The discharge MDS documented Resident #290 had 1 Stage 3 pressure ulcer.

An occupation therapy discharge note dated 12/14/2021 documented Resident #290 required minimal assistance with toileting, dressing, bathing, and meal preparation from wheelchair level. The occupational therapy note documented Resident #290 required assistance due to fatigue and dyspnea, and oxygen saturation levels dropped with exertion.

A certified occupational therapist aide (COTA) #2 was interviewed on 1/4/2022 at 3:59 PM. COTA #2 reported she provided therapy to Resident

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#290 and she had discussions with Resident #290 about what she needed in her home after discharge from the facility. COTA #2 explained Resident #290 had been given a reaching device and a sock aid by the facility, but she would need a wheelchair and a bedside commode to use as a toilet seat extender. COTA #2 reported Resident #290 was extremely short of breath with any activity and that home health was recommended to continue therapy.

The Unit Manger (UM) was interviewed on 1/4/2022 at 12:25 PM. The UM reported that Resident #290 was discharged sometime after 4:00 PM on 12/13/2021. The UM reported when Resident #290 was discharged, the nursing staff, the resident and the family member were under the impression home health services would start on 12/14/2021.

A follow-up interview was conducted with the UM on 1/5/2021 at 11:20 AM. The UM reported she and all the department heads had received an email from the SW on 12/13/2021 at 8:21 AM that reported Resident #290 was to be discharged home with the named home health agency that would provide nursing, PT and OT services to her. The UM reported that she did not receive any notification prior to the resident ' s discharge that the services would not be available. She noted that if they had, extensive education for her wound care would have been provided to the resident and the family member. The UM also stated they would have sent some supplies and found resources for her to get wound care supplies.

The family member of Resident #290 was interviewed on 12/28/2021 at 12:12 PM. The

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family member reported Resident #290 was discharged from the facility on 12/13/2021 after 4:00 PM and when she returned to Resident #290 ' s home, she found no medical equipment had been delivered for Resident #290. The family member reported she had to purchase equipment for Resident #290, including a walker, bed rails, shower chair, hand-held shower device, and an elevated toilet seat. The family member reported 3 people assisted Resident #290 up the 19 stairs to her home on 12/13/2021. The family member reported Resident #290 was extremely short of breath and could take only one step at a time with 2 people holding onto her and assisting her to lift onto each step. The family member reported on 12/14/2021 she called the facility and spoke to the Social Worker (SW) to inquire when home health would arrive. The family member reported the SW told her that the home health agency could not provide services to Resident #290, but he was attempting to find a replacement home health agency.

The SW was interviewed on 12/30/2021 at 11:59 AM. The SW explained he was responsible for ordering equipment for residents discharging to home, as well as setting home health services. The SW reported Resident #290 ' s insurance had issued a notice of non-coverage on 12/2/2021, and Resident #290 appealed that decision. The insurance company approved for a few more days of therapy. The SW reported when a second notice of non-coverage was issued, Resident #290 appealed, but the appeal was denied. The SW reported Resident #290 was unable to pay privately for services and had said she would go home. The SW reported he made the referral to home health on 12/13/2021 and he was contacted by the home health agency on

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12/13/2021 to notify the facility that they were unable to provide care to Resident #290 due to staffing issues. The SW reported he attempted to find another home health agency to provide services to Resident #290 without success.

The Home Health Agency Marketing Manager (HHA) was interviewed on 12/30/2021 at 3:39 PM. The HHA reported she had received the referral for Resident #290 on 12/13/2021 and she had contacted the local home health agency, but due to staffing issues, they were not able to provide services to Resident #290. The HHA reported she talked to several other home health offices within their organization, but no one was able to provide services. The HHA reported she notified the SW at the facility, but she was unable to recall the time of day she contacted him to notify him that her organization could not provide services to Resident #290.

The SW was interviewed again on 1/4/2022 at 2:28 PM. the SW reported he had been notified by the home health agency at lunch time by phone that they were unable to accept Resident #290. The SW reported he did not notify Resident #290, her family, the physician, or the facility staff, and he instead attempted to find another home health agency to provide care to Resident #290, but he was unsuccessful. The SW reported he was not aware Resident #290 did not leave the building until after 4:00 PM. The SW reported he thought Resident #290 had discharged early in the morning on 12/13/2021 and he thought she was already at home when he was told the home health agency was unable to provide services to her.

An interview was conducted with the SW on

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1/5/2022 at 10:32 AM. The SW reported he was aware Resident #290 was going back to her home and she had 19 steps to get into the home. The SW reported he did not recall hearing that Resident #290 required total assistance to ascend more than 12 steps. The SW reported he had not notified Resident #290 or the facility staff about home health not being able to admit her to services because he felt he could find another home health agency to provide services to her.

An interview was conducted with Resident #290 on 12/28/2021 at 2:47 PM. Resident #290 reported she was discharged from the facility on 12/13/2021 after 4:00 PM and she understood she was to have home health physical therapy and a nurse. Resident #290 was discharged to home without medical equipment to assist with bathing, grooming, hygiene, or toileting. Resident #290 reported she had 19 steps to ascend to get to her home and she required 3 people to assist her, one person carried her oxygen tank, and she had a person on each side of her to help her up the steps. Resident #290 explained she would take one step at a time and rest after each step and the effort was very taxing and fatiguing. Resident #290 reported on 12/14/2021 her family member called the facility to find out when home health was going to arrive, and her family member was told by the SW that the home health agency did not accept her, and the SW was attempting to find another home health agency. Resident #290 reported she had to rely on assistance from her family member to provide hygiene, grooming, toileting, transfers, and meal preparation. Resident #290 reported she lived alone in a 2nd story apartment without an elevator and her family member lived about 5 minutes away by car. Resident #290 reported no

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home assessment was completed by the facility, a wheelchair was ordered, but it was backordered and not delivered prior to her discharge home from the facility. Resident #290 reported her family member had to purchase equipment and wound care supplies for her use in the home. Resident #290 was incontinent of urine and feces and required an incontinence brief. Resident #290 stated she was not able to get to the bathroom or change her brief upon discharge and had terrible pain at the pressure ulcer site when she was incontinent.

Resident #290 was interviewed again on 1/4/2022 at 3:31 PM. Resident #290 reported when she returned home, she reviewed her discharge instructions and saw there were no wound care orders. Resident #290 reported a home health agency was listed on the discharge instructions and she thought the home health agency would look at her pressure ulcer and get orders. Resident #290 reported her family member had purchased a walker to assist with transfers into the bathroom. Resident #290 reported she was able to stand for 1-2 minutes before she was fatigued and had to sit down. Resident #290 reported she needed to use incontinence briefs because she was not able to get to the bathroom in time, and her family member came to her house several times per day to help her perform hygiene after incontinence. Resident #290 said with help she would use the walker and she could walk to the toilet. She noted that it was tough, and she would have to go in her pants at times if she had no help. Resident #290 reported she had used a brief every day and night and when she was wet or soiled her pressure ulcer hurt. She stated, "my sores looked terrible when I got home, and they hurt so bad." She said she would

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have to wait till her family member got there and got her cleaned up. Resident #290 reported because it was the holiday season, her family member was available to help her as often as she needed assistance. Resident #290 further reported her family member would get her food and drinks when the family member came to her home. Resident #290 reported if there was an emergency, she would call her family member, but Resident #290 did not have a plan to exit her home safely. Resident #290 reported she had a long cord for her oxygen, and she had to wear the oxygen all the time. Resident #290 explained when she performed activities, she had to increase the flow of oxygen, but that did not prevent her from having shortness of breath. Resident #290 reported she had a virtual visit with her personal physician, and he recommended a topical cream to apply to her pressure ulcer sites and made a referral to home health for her. Resident #290 did not receive home health services until 12/30/2021.

Nurse #10 was interviewed on 1/4/2022 at 2:06 PM. Nurse #10 reported she discharged Resident #290 from the facility at 5:30 PM. The nurse reported Resident #290 ' s family member picked her up at the facility and the discharge instructions were reviewed with the family member and Resident #290. Nurse #10 reported she was not aware Resident #290 did not have home health services set up, or instructions for pressure ulcer care, that Resident #290 had to ascend 19 steps to her home, or that Resident #290 did not have medical equipment in the home, including the wheelchair. Nurse #10 reported if she knew Resident #290 did not have home health, she would have provided wound care teaching to Resident #290 and her family.

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The home health nursing admission completed 12/30/2021 documented Resident #290 was prescribed oxygen at 5 liters per minute and she was dyspneic with activity. The admission assessment documented Resident #290 was unable to ambulate on a level surface without assistive device, was unable to transfer self, unable to ambulate to and from the toilet, required moderate assistance to transfer on and off the toilet, and required moderate assistance to perform toileting hygiene. The home health nursing admission assessment documented Resident #290 required moderate assistance to dress lower body. The assessment documented Resident #290 had "4" (1-10 scale, with 10 being worst) pain at the pressure ulcer site daily. The nursing admission assessment documented Resident #290 reported feeling unsteady when standing or walking and she was afraid of falling.

Home Health Nurse #1 was interviewed on 1/10/22 at 10:54 AM regarding Resident #290. She stated she had completed the resident ' s initial assessment for home health services on 12/30/2021. She noted the family member had been applying a protective cream and the pressure ulcer on her bottom had closed, however home health would continue to monitor it. She noted the resident had stated she had pain at the pressure ulcer site and the home health nurse had recommended a pressure relieving device for her chair. The Home Health Nurse #1 reported Resident #290 was able to get to her bathroom and her kitchen, if someone was there for assistance, but it was a taxing effort.

The home health PT was interviewed 1/5/2022 at 1:03 PM. The home health PT reported there was

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concern for Resident #290 because she lived in a 2nd floor apartment without an elevator, was extremely weak, and she was unable to ascend or descend stairs. The home health PT reported Resident #290 ' s oxygen saturation level decreased to 77% (normal 90-100%) during ambulation and it took her approximately 2 minutes for her to recover from activity. The home health PT reported Resident #290 ' s family member had to purchase a walker, bed rails, shower chair, hand-held shower device, and an elevated toilet seat because those items were not ordered by the facility.

The Nurse Practitioner (NP) was interviewed on 12/30/2021 at 12:09 PM. the NP reported she was not aware Resident #290 had been discharged home without home health services in place.
A follow up interview was conducted on 1/04/2022 at 5:50 PM with the NP regarding Resident #290 ' s discharge. The NP stated she was not notified that home health would not be provided, and she would have expected to be notified if Resident #290 was not going to receive home health services. The NP was asked if the resident was negatively affected by not having orders for pressure ulcer care and having home health to follow her. The NP reported if no home health could see her, she would have expected to be called for wound care and other orders. The NP reported she would have expected her to see a physician sooner and the nursing staff should have done education on how to do the pressure ulcer wound dressing.

Resident #290 ' s Physician (MD) was interviewed via phone on 1/5/2022 at 10:04 AM regarding her discharge. The MD stated he would have

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expected when the home health resources were not able to be provided for Resident #290 that this would be communicated, and he was not made aware of home health had not accepted Resident #290. The MD reported alternate resources should have been looked for by the facility prior to her leaving the facility and the family member and resident should have been provided education. The MD reported Resident #290 had a risk for harm related to her respiratory status and inability to ascend stairs, and she was fortunate that nothing negative happened to her.

An interview was conducted on 1/4/2022 at 5:22 PM with the Administrator and the Director of Nursing (DON). The Administrator reported if home health was needed by a resident, it was arranged by the SW to the best of their ability and if home health could not be arranged, the facility should have notified the family. The Administrator reported that the discharge was not ideal, but Resident #290 was unable to pay for additional services at the facility. The DON reported Resident #290 should have gone home with home health services in place. The DON stated if home health was not in place, the facility should have provided education to the resident and the family member to manage her care. The DON reported Nurse #10 thought home health was set up and she discharged Resident #290 to home based on that information.

The Administrator was interviewed again on 1/5/2022 at 5:17 PM. The Administrator reported she did not believe the facility, or the SW intended to unsafely discharge Resident #290 home without home health services or equipment. The Administrator reported Resident #290 ' s family member was insistent to take

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Resident #290 home, and if the family member reported she was unable to provide care for Resident #290, the facility would have allowed her to stay at the facility.

The Administrator and DON were notified of Immediate Jeopardy on 1/5/2022 at 5:22 PM.

The facility provided a credible allegation of Immediate Jeopardy removal on 1/6/2022.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Deficient practice occurred on 12-13-21 when resident #290 was discharged home without a safe and appropriate discharge plan in place.

All other discharges to home that occurred after 12-13-21 will be reviewed by 1-6-22 by the corporate discharge planning specialist to determine any potentially unsafe discharge plans. Immediate action will be taken if any deficient practice is identified, the Administrator and/or appropriate IDT member will contact the family and offer any assistance with services they may require. The Administrator and Corporate discharge planning specialist educated discharge planner on discharge planning role in skilled/ transitional care on 1-6-22. Future discharge planning will be discussed with administrator prior to discharge of resident.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
Discharge planner will be educated on Discharge planning role in skilled/transitional care by the

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administrator and Corporate discharge planning specialist on 01/06/2021 to ensure a safe and appropriate discharge plan.

The discharge planner specifically will be educated to complete the following tasks, as per policy:
1. Within 24 hours of admission or first business day if on weekend discharge planner will confirm patient/responsible party plans and support
2. Discharge Planner will identify post discharge needs with the interdisciplinary team daily in morning patient review meetings
3. Keep interdisciplinary team informed of discharge planning initiatives
4. Assist with, apply for, and/or secure needed services post discharge to include DME, Personal Care, and home health services.
5. Finalize and confirm services prior to discharge
6. Communicate all discharge plans with the patient, RP, and/or interested parties

If at any time the discharge planner has any question of safety during the discharge process, discharge planner will discuss with the IDT team immediately to form a resolution in order to ensure a safe and appropriate discharge to home. If warranted, a home assessment will be completed.

The Interdisciplinary team will be educated by VP of Operations and Corporate Discharge Planning Specialist on the policy on discharge planning, including the 6 areas above in skilled and transitional care. Education will also include to bring potential barriers to discharge to the attention of the discharge planner and other members of the team, in order to address these

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F 624	Continued From page 17 barriers prior to discharge. Examples are included but not limited to functional abilities, clinical needs, psychosocial needs, or an inability to access any recommended services upon discharge from the center. This education will be completed on 01/06/2021. The interdisciplinary team consist of Administrator, Director of Nursing, MD/Medical Provider, nurse manager, Director of Rehab, Discharge planner/social worker, and Dietary Manager. All discharges will be reviewed by the Interdisciplinary Care team and agreed upon by all relevant disciplines prior to the actual discharge. The administrator will be responsible for compliance. Date of immediate jeopardy removal 01/07/22. As part of the on-site validation process on 1/10/2022, the credible allegation was reviewed which included dates and content of the in-services that were conducted with the SW and the interdisciplinary team, including the Administrator, the DON, rehab therapy manager, the NP, and other department heads. Multiple staff were interviewed and verified they had received education on the facility discharge process. The facility ' s IJ removal date of 1/7/2022 was validated.	F 624		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 637		2/14/22

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F 637	Continued From page 18 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a significant change MDS (Minimum Data Set) for 1 of 1 residents reviewed for significant change (Resident #32). The findings included: Resident #32 was admitted to the facility on 04/02/2021 with a diagnosis of arthritis. A review of an admission Minimum Data Set (MDS) assessment dated 04/08/2021 revealed that Resident #32 had severe cognitive impairment and was frequently incontinent of bladder and bowel. Resident #32 had no pain, no falls and did not receive an anticoagulant medication. A review of a nurse progress note dated 10/22/2021 at 1:58 PM revealed that Resident #32 had sustained a fall on 10/21/2021 and he did not exhibit signs or symptoms of pain until 10/22/2021 experienced left leg pain the NP (nurse practitioner). The NP ordered left leg x-rays immediately and it was discovered that Resident #32 had a left femur fracture and was sent to the hospital. Previous x-rays dated 10/12/2021 had been obtained and no fracture was evident at that time.	F 637	F637 What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Minimum Data Set coordinator and Interdisciplinary team will schedule a significant change minimum data set for current resident who sustains a fracture from a fall. A significant Change minimum data set assessment was completed and transmitted for resident #32 on 12/29/21 to address the resident□s decline from fracture. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents in the center have the potential to be affected. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Regional Minimum Data Set Nurse	

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F 637	Continued From page 19 Resident #32 was readmitted to the facility on 10/27/2021 with diagnoses that included fall with left hip fracture and repeated falls. A review of a 5- day MDS dated 11/03/2021 revealed Resident #32 had severe cognitive impairment, was always incontinent of bladder and bowel, received scheduled and as needed (prn) pain medication, had a fall with fracture in the last 30 days with a surgical wound and received an anticoagulant medication for six of the review days. An interview was conducted with NA (nurse assistant) #2 on 01/04/2022 at 12:55 PM. The NA explained that Resident #32 required more care assist after he returned from the hospital for hip surgery. On 01/04/2022 at 1:01 PM an interview was conducted with the COTA (certified occupational therapist) familiar with Resident #32. The COTA explained that prior to the fall and hip fracture Resident #32 had been participating in occupational therapy and making progress, but he was not placed on her caseload since his return based on the physician's decision and that she had not observed Resident #32 out of bed ambulating since his readmission. During an interview with the MDS nurse conducted on 01/04/2022 at 10:58 AM, she explained she did not believe that Resident #32 had returned from the hospital on 10/27/2021 with any significant change in his status and that she was not aware of what the RAI (Resident Instrument Manual) was and had never seen it or utilized it to complete MDS assessments or to	F 637	Consultant will audit current residents with declines from fractures Minimum Data Set assessments for previous 2 months to ensure significant change assessment was completed or is scheduled. Minimum Data Set coordinators were educated by Regional Minimum Data Set Nurse Consultant regarding the resident assessment instrument manual guidelines used to determine if a significant change assessment is necessary and definition of significant change. In clinical meeting (Monday-Friday) both Minimum Data Set coordinators and interdisciplinary team will evaluate and compare current Minimum Data Set to previous Minimum Data set to determine if a significant change has occurred. The daily 24 hour clinical report will be reviewed to determine if the assessment is necessary. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Regional Minimum Data Set Nurse consultant or designee will audit 5 Minimum Data Sets weekly for 4 weeks, biweekly for 8 weeks, and then monthly for 2 months until such time that the Quality Assurance committee determines that the issue is resolved The administrator is responsible for implementing the acceptable plan of correction	

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F 637	Continued From page 20 review significant change requirements. The MDS nurse reported that she had never initiated a significant change MDS unless instructed to do so by the Regional Data Analysis and Verification Specialist. The MDS nurse reported that she had been employed at the facility for about one and a half years as the MDS nurse. On 01/04/2022 at 2:52 PM an interview conducted with the facility administrator revealed that all residents to have a complete and accurate MDS to reflect each resident's status as required by the RAI (Resident Assessment Manual) this included all significant change, quarterly and comprehensive MDS assessments.	F 637	Date of completion 2/14/22.	
F 641 SS=E	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 observations, record review and staff and resident interview the facility failed to accurately code the Minimum Data Set (MDS) assessments for 8 of 9 residents reviewed for MDS accuracy. Residents #59, # 52, # 20 and # 69 were not coded for Level ll Preadmission Screening and Resident Review (PASRR). Residents # 348, # 290 and # 88 were not accurately coded for discharge planning and Resident # 64 was not accurately coded for hospice services. Findings included: 1.Resident #59 was admitted to the facility on	F 641	F641 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Residents #59, # 52, # 20 and #69 MDS were modified to code for Level ll Preadmission Screening and Resident Review (PASRR) as followed: #59Minimum Data Set (MDS) completed on 1/19/22 by MDSC, #52 MDS completed 2/4/22 by Minimum Data Set Coordinator(MDSC), #20 MDS completed	2/14/22

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F 641	Continued From page 21 11/29/2021 with diagnoses that included major depression and adult failure to thrive. A review of a comprehensive significant change MDS dated 06/15/2021 revealed that Resident # 59 was not coded for PASRR Level II at section A1500 for Level II PASRR screening and Resident # 59 was not coded at section A1510 for Level II PASRR conditions as required by the RAI (Resident Assessment Manual). A letter dated 06/25/2021 to the facility from the North Carolina Department Of Health And Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 59 had been determined to require a Level II PASRR. An interview conducted with the discharge planner (DP) on 12/30/2021 at 12:12 PM revealed that the DP was responsible for coding section A1500 and A1510 of comprehensive MDS assessments to indicate if the resident was a PASRR Level II or not. The DP also revealed that after admission the PASRR status of residents was not discussed and that PASRR status was not recorded in the EMRs (electronic medical records) of any residents. On 01/04/2022 at 10:58 AM an interview was conducted with the MDS nurse. The MDS nurse stated that she did not code Level II PASRR status of any resident on any MDS and that was the responsibility of the DP. The facility administrator was interviewed at 2:52 PM on 01/04/2022 and she stated that it was expected that the MDS sections related to Level II PASRR status be coded correctly for each	F 641	1/17/22 by MDSC, and #69 MDS completed 2/7/22 by MDSC. Residents # 348, # 290 and # 88 MDS were modified to accurately coded for discharge planning and Resident # 64 was modified to accurately coded for hospice services How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: An audit will be conducted for current residents in the center to ensure that PASRR has been completed as required. If required including residents on hospice services and those with discharge plans. The audit will include section A, O, and Q to ensure accuracy. New admissions will be audited for sections A, O, and Q for accuracy Measures to be put in place or systemic changes made to ensure practice will not re-occur: Regional MDS Nurse Consultant will audit current residents with Level II Preadmission Screen and Resident Review (PASRR), receiving hospice services, and with discharge plans to ensure most recent MDS assessments are accurately coded. MDSCs were educated by Regional MDS Nurse Consultant on 2/1/22 on Resident assessment Instrument(RAI) Manual instructions for coding Level II PASRR on Comprehensive MDS, Hospice and Discharge Plans on MDS. Discharge	

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F 641	Continued From page 22 resident as required by the RAI manual. 2.Resident # 52 was readmitted to the facility on 07/26/2018 with diagnoses that included major A letter dated 10/30/2014 from the North Carolina Department Of Health And Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 52 had an existing Level ll PASRR and that the PASRR number was to remain in place until it expired. depression, intellectual disability and seizure disorder. A review of a comprehensive annual MDS dated 08/19/2021 revealed that Resident # 52 was not coded for PASRR Level ll at section A1500 for Level ll PASRR screening, at A1510 for Level ll PASRR condition and Resident # 52 was not coded at A1550 for conditions related to MR (Mental Retardation)/ DD (Developmental Disability) for Level ll PASRR as required by the RAI manual. An interview conducted with the discharge planner (DP) on 12/30/2021 at 12:12 PM revealed that the DP was responsible for coding section A1500 , A1510 and A1550 of comprehensive MDS assessments to indicate if the resident was a PASRR Level ll or not. The DP also revealed that after admission the PASRR status of residents was not discussed and that PASRR status was not recorded in the EMRs (electronic medical records) of any residents. On 01/04/2022 at 10:58 AM an interview was conducted with the MDS nurse. The MDS nurse stated that she did not code Level ll PASRR status of any resident on any MDS and that was the responsibility of the DP.	F 641	Planner was educated by MDSC Consultant on 2/3/22 on RAI Manual instructions for coding Level II PASRR on Comprehensive MDS, and Discharge Plans on MDS. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Regional MDS Nurse Consultant or designee will audit to ensure the accuracy of section A and O of the MDS 5 MDSs weekly for 4 weeks, biweekly for 8 weeks, then monthly times 2 months until such time that the QAPI committee determines that the issue is resolved The administrator is responsible for implementing the acceptable plan of correction DATE OF COMPLIANCE: 2/14/22	

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The facility administrator was interviewed at 2:52 PM on 01/04/2022 and she stated that it was expected that the MDS sections related to Level ll PASRR status be coded correctly for each resident as required by the RAI manual.

3.Resident # 20 was admitted to the facility on 07/28/2021 with diagnoses that included bipolar disorder and anxiety.

A letter to the facility dated 07/22/2021 from the North Carolina Department Of Health And Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 20 had a Level ll PASRR.

A review of a comprehensive admission MDS for Resident # 20 dated 08/03/2021 revealed that Resident # 20 was not coded with a Level ll PASRR at section A1500 or A1510 to indicate the level ll PASRR status of Resident # 20.

An interview conducted with the discharge planner (DP) on 12/30/2021 at 12:12 PM revealed that the DP was responsible for coding section A1500 , A1510 and A1550 of comprehensive MDS assessments to indicate if the resident was a PASRR Level ll or not. The DP also revealed that after admission the PASRR status of residents was not discussed and that PASRR status was not recorded in the EMRs (electronic medical records) of any residents.

On 01/04/2022 at 10:58 AM an interview was conducted with the MDS nurse. The MDS nurse stated that she did not code Level ll PASRR status of any resident on any MDS and that was

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the responsibility of the DP.

The facility administrator was interviewed at 2:52 PM on 01/04/2022 and she stated that it was expected that the MDS sections related to Level ll PASRR status be coded correctly for each resident as required by the RAI manual.

4.Resident # 69 was admitted to the facility on 02/19/2021 with diagnoses that included Parkinson's disease, major depression and epilepsy.

A letter dated 01/21/2021 to the facility from the North Carolina Department Of Health And Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 69 had a Level ll PASRR number in place and it remained in place until it expired.
A review of a comprehensive significant change MDS dated 06/15/2021 revealed that Resident # 69 was not coded with a Level ll PASRR at sections A1500, A1510 and A1550 to indicate that Resident # 69 had a Level ll PASRR.

An interview conducted with the discharge planner (DP) on 12/30/2021 at 12:12 PM revealed that the DP was responsible for coding section A1500 , A1510 and A1550 of comprehensive MDS assessments to indicate if the resident was a PASRR Level ll or not. The DP also revealed that after admission the PASRR status of residents was not discussed and that PASRR status was not recorded in the EMRs (electronic medical records) of any residents.

On 01/04/2022 at 10:58 AM an interview was conducted with the MDS nurse. The MDS nurse

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stated that she did not code Level ll PASRR status of any resident on any MDS and that was the responsibility of the DP.

The facility administrator was interviewed at 2:52 PM on 01/04/2022 and she stated that it was expected that the MDS sections related to Level ll PASRR status be coded correctly for each resident as required by the RAI manual.

5. Resident #348 was admitted to the facility on 12/14/2021 with diagnosis of stroke, diabetes, and kidney disease.

A discharge plan dated 12/20/2021 documented Resident #348 was admitted for a short-term stay.

A care plan dated 12/20/2021 documented Resident #348 ' s discharge plan and included his preference to be discharged home.

The admission Minimum Data Set (MDS) assessment dated 12/24/2021 assessed Resident #348 to be cognitively intact. The MDS documented no discharge plan was in place for Resident #348.

An interview was conducted with Resident #348 ' s family member on 12/29/2021 at 3:43 PM. The family member reported Resident #348 would be discharged home on 12/31/2021.

An interview was conducted with the Social Worker (SW) on 1/4/2022 at 2:45 PM. The SW

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reported he completed the discharge section of the MDS. The SW reported he talked to residents and their family members within 72 hours of admission to the facility and most residents don ' t have a specific discharge plan in place other than they want to go home. The SW reported he added the care plan for all residents to address their discharge preferences but was not aware he should answer "yes" to a discharge plan was in place on the admission MDS.

The MDS nurse was interviewed on 1/4/2021 at 2:58 PM. The MDS nurse reported she had not reviewed the SW documentation in the MDS for discharge planning.

The Administrator was interviewed on 1/4/2022 at 4:36 PM. the Administrator reported she was not aware the SW was answering the MDS discharge plan "no" for short-term residents. The Administrator reported she expected the MDS to be coded accurately.

6. Resident #290 was admitted to the facility 11/16/2021 with diagnoses to include viral pneumonia, hypertension, and chronic obstructive lung disease (COPD).

A discharge plan dated 11/21/2021 documented Resident #290 was admitted for a short-term stay.
The admission MDS dated 11/22/2021 documented no discharge plan was in place for Resident #290.

A care plan dated 12/2/2021 documented Resident #290 ' s discharge plan and her preference to discharge home.

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Resident #290 was interviewed on 12/28/2021 at 2:47 PM. Resident #290 reported she planned to discharge home when she was admitted to the facility.

An interview was conducted with the SW on 1/4/2022 at 2:45 PM. The SW reported he completed the discharge section of the MDS. The SW reported he talked to residents and their family members within 72 hours of admission to the facility and most residents don ' t have a specific discharge plan in place other than they want to go home. The SW reported he added the care plan for all residents to address their discharge preferences but was not aware he should answer "yes" to a discharge plan was in place on the admission MDS.

The MDS nurse was interviewed on 1/4/2021 at 2:58 PM. The MDS nurse reported she had not reviewed the SW documentation in the MDS for discharge planning.

The Administrator was interviewed on 1/4/2022 at 4:36 PM. the Administrator reported she was not aware the SW was answering the MDS discharge plan "no" for short-term residents. The Administrator reported she expected the MDS to be coded accurately.

7. Resident #88 was admitted to the facility 12/14/2021 with Guillain-Barre syndrome, urinary tract infection, and arthritis.

The discharge plan for Resident #88 dated 12/19/2021 documented she was admitted for a short-term stay.

The admission MDS dated 12/20/2021 assessed

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Resident #88 to be cognitively intact. The MDS documented no discharge plan was in place.

A care plan dated 12/20/2021 documented Resident #88 planned to discharge to home.

Resident #88 and her family member were interviewed on 12/28/2021 at 10:37 AM. Resident #88 reported she was planning to return home and the facility was aware. Resident #88 reported she needed to meet some goals in therapy before she could go home. Resident #88 ' s family member reported no home visit had been completed, but the SW had talked to him about discharge.

An interview was conducted with the SW on 1/4/2022 at 2:45 PM. The SW reported he completed the discharge section of the MDS. The SW reported he talked to residents and their family members within 72 hours of admission to the facility and most residents don ' t have a specific discharge plan in place other than they want to go home. The SW reported he added the care plan for all residents to address their discharge preferences but was not aware he should answer "yes" to a discharge plan was in place on the admission MDS.

The MDS nurse was interviewed on 1/4/2021 at 2:58 PM. The MDS nurse reported she had not reviewed the SW documentation in the MDS for discharge planning.

The Administrator was interviewed on 1/4/2022 at 4:36 PM. the Administrator reported she was not aware the SW was answering the MDS discharge plan "no" for short-term residents. The Administrator reported she expected the MDS to

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F 641	Continued From page 29 be coded accurately. 8. Resident #64 was admitted to the facility on 1/19/21 with diagnoses that included chronic kidney disease, heart failure, Chronic Obstructive Lung Disease (COPD), diabetes and dementia. Record review indicated Resident #64 had a hospice order placed on 03/04/21. The Quarterly Minimum Data Set (MDS) assessment dated 12/01/21 indicated Resident #64 was not coded for less than 6 months prognosis or for hospice. An interview was conducted with the MDS Nurse on 01/04/22 at 2:25 PM. She reviewed the 12/01/21 quarterly MDS assessment for Resident #64 and noted this was coded inaccurately and the prognosis for less than 6 months and hospice was not marked. She stated they should have been marked accurately. An interview was done with the Director of Nursing, Administrator and Regional Director of Clinical Services on 01/04/22 at 5:14 PM regarding Resident #64's MDS documentation related to his prognosis and hospice care. The DON and the Administrator both stated they expected the MDS to be coded accurately.	F 641		
F 656 SS=E	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	F 656		2/14/22

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F 656	Continued From page 30 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive 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 reviews, observations and resident and staff interviews the facility failed to develop and implement comprehensive care	F 656	F656 How corrective action will be	

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F 656	Continued From page 31 plans for 3 of 9 residents reviewed for care plans (Residents #59, Resident #32 and Resident #91). Findings included: 1.Resident # 59 was admitted to the facility on 11/29/2021 with diagnoses that included congestive heart failure (CHF), acute respiratory failure, failure to thrive and major depression. The admission MDS (minimum Data Set) dated 12/04/21 revealed that Resident # 59 was had severe cognitive impairment, cavity and or broken natural teeth. Resident # 59 was also received an antidepressant medication and a diuretic medication for 5 days and she wore oxygen. A review of the Care Area Assessments (CAAs) on 12/04/2021 for Resident # 59 revealed that a care plan (CP) would be developed for dental status, antidepressant and diuretic use. The CPs for Resident #59 were reviewed and revealed there was no CP in place for Resident #59 related to dental status, antidepressant or diuretic use. There was no CP in place that revealed that Resident # 59 wore oxygen. The MDS was interviewed on 01/04/2022 at 10:58 AM. The MDS nurse revealed that she completed most of the admission MDS for Resident # 9. The MDS nurse revealed that Resident #59 required CPs related to dental status, medications or oxygen and that just because she checked the box to proceed to CP on the CAAs, she did not always develop those CPs and she was not familiar that she was supposed to CP those areas or develop CPs for	F 656	accomplished for each resident found to have been affected by the deficient practice: Resident #59 is no longer a resident in the facility. Resident #91 is no longer a resident in the facility. Resident #32 comprehensive care plan has been updated/revised to reflect bladder and bowel incontinence, fall with fall intervention, and current skin impairments. Resident #32 is no longer receiving anticoagulation medication. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents in the center have the potential to be affected. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Minimum Data Set Coordinators, Unit managers, and Director of Nursing were educated by Regional Minimum Data Set Nurse Consultant regarding completion of care area assessments, completion and updating of comprehensive care plans related to dental, Activities of Daily living, bowel and bladder status, psychotropic drug use, falls, and pressure ulcers, and advanced directives Current residents care plans will be audited for accuracy to ensure they include dental status, activities of daily living, bowel and bladder status, psychotropic drug use, falls, pressure ulcers, and advanced directives and will be edited by Unit managers, Director of Nursing, or designee if needed.	

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F 656	Continued From page 32 areas coded on the MDS that did not have a specific CAA. On 1/04/2022 at 2:52 PM an interview conducted with the facility administrator revealed that she expected that all residents required comprehensive care plans that were individualized for each resident as required in the RAI (Resident Assessment Manual). 2. Resident #32 was readmitted to the facility on 10/27/2021 with diagnoses that included fall with left hip fracture, anxiety and repeated falls. A review of an MDS dated 11/03/2021 revealed that Resident #32 had severe cognitive impairment, was always incontinent of bladder and bowel, had a fall in the past month, a left hip surgical wound and received an anticoagulant medication for six of the review days. An initial wound physician(MD) note dated 11/10/2021 revealed that Resident #32 had a facility acquired deep tissue injury of the left heel and a facility acquired trauma wound of the left calf. The care plans for Resident #32 were reviewed and there was no CP in place for bladder and bowel incontinence at all times, no CP for an actual fall with specific fall prevention interventions in place. Resident # 32 did not have a CP in place for care of the left hip surgical site care or a CP in place for actual skin breakdown and no CP for the use of anticoagulant medication. The MDS was interviewed on 01/04/2022 at 10:58 AM. The MDS nurse explained that she	F 656	New resident□s documentation will be reviewed by Unit managers, Director of Nursing, minimum data set coordinators, and interdisciplinary team during daily clinical meeting and care plans will be initiated and updated to reflect activities of daily living, bowel and bladder, psychotropic drug use, falls, pressure ulcers, dental status, and advanced directives. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Regional Minimum Data Set Nurse Consultant or designee will audit 5 minimum data set weekly for 4 weeks, biweekly for 8 weeks, then monthly for 2 months, until such time that the Quality Assurance committee determines that the issue is resolved. The administrator is responsible for implementing the acceptable plan of correction Date of Compliance: 2/14/22	

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was not the only nurse responsible to update care plans and that the nurses on each unit were to also update resident care plans. The MDS nurse explained that she never had proper training about developing comprehensive care plans. The MDS nurse revealed that she completed care plans only as directed by her corporate consultant.

On 1/04/2022 at 2:52 PM an interview conducted with the facility administrator revealed that she expected that all residents required comprehensive care plans that were individualized for each resident as required in the RAI (Resident Assessment Manual).

3. Resident #91 was admitted to the facility 2/24/2021 with diagnosis to include heart failure, pneumonia, and heart disease. The quarterly Minimum Data Set (MDS) assessment dated 12/3/2021 assessed Resident #91 to be moderately cognitively impaired.

Resident #91 ' s medical chart was reviewed, and a physician order dated 2/24/2021 was noted: "do not resuscitate".

The care plans for Resident #91 were reviewed. No care plan was in place related to the do not resuscitate order.

Resident #91 died in the facility on 12/7/2021.

Nurse #7 was interviewed on 12/30/2021 at 10:44 AM. Nurse #7 reported he admitted Resident #91 to the facility, but he did not specifically remember Resident #91. Nurse #7 reported when a resident is admitted to the facility, the MDS

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F 656	Continued From page 34 nurse usually is responsible for initiating all care plans. The MDS nurse was interviewed on 1/4/2022 at 2:58 PM. The MDS nurse reported she completed the admission MDS assessment on Resident #91. The MDS reported a care plan should have been developed by the staff at the time the order was written. The MDS nurse reported she was not aware a care plan needed to be developed for a do not resuscitate order. The MDS nurse reported she was not aware no care plan had been developed for Resident #91 related to the do not resuscitate status order written on 2/24/2021. The MDS nurse reported the interdisciplinary team should have noticed the care plan had not been written and developed a care plan related to Resident #91 ' s do not resuscitate status. The Administrator was interviewed on 1/4/2022 at 4:36 PM. The Administrator reported she expected care plans to accurately reflect the needs of residents.	F 656		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		2/14/22

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F 732	Continued From page 35 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 6 of 6 posted nurse staffing sheets reviewed. Findings included: Staffing sheets for 9/11/2021, 9/12/2021, 9/13/2021, 12/11/2021, 12/12/2021, and 12/13/2021 were reviewed and revealed the following were not accurate on the following 6 of 6	F 732	F732 How corrective action will be accomplished for those residents found to have been affected: Nursing staffing sheets were corrected for the dates found to be incorrect: 9/11/21, 9/12/21, 9/13/21, 12/11/21, 12/12/21, 12/13/21. How the facility will identify other residents	

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F 732	Continued From page 36 days: a. The nursing schedule for 9/11/2021 for day shift (6:00 AM to 2:00 PM) indicated 6 nursing assistants (NAs) were scheduled to work that date. The daily posted nurse staffing summary reported 6.5 NAs provided 48.75 hours of care on day shift. The nursing schedule for 9/11/2021 for afternoon shift (2:00 PM to 10:00 PM) indicated 6 NAs were scheduled to work. The daily posted nurse staffing summary reported 5 NAs had provided 37.5 hours of care that shift. b. The nursing schedule for 9/12/2021 for night shift (10:00 PM to 6:00 AM) indicated 5 NAs were scheduled to work. The daily posted nurse staffing summary reported 3 NAs had provided 22.5 hours of care for that shift. c. The nursing schedule for 9/13/2021 indicated 5 NAs were scheduled to work afternoon shift that date. The daily posted nurse staffing summary reported 3.5 NAs provided 26.25 hours of care that shift. The nursing schedule indicated 5 NAs were scheduled to work night shift on 9/13/2021. The daily posted nurse staffing summary reported 3 NAs had provided 22.5 hours of care that shift. d. The nursing schedule for 12/11/2021 indicated 8 NAs were scheduled to work on day shift that date. The daily posted nurse staffing summary reported 10 NAs had provided 75 hours of care that shift. The nursing schedule for 12/11/2021 afternoon shift indicated 7 NAs were scheduled to work afternoon shift. The daily posted nurse staffing sheet reported 9 NAs had provided 67.5 hours of care that shift. e. The nursing schedule for 12/12/2021	F 732	having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Nursing or designee will audit last 2 weeks of staffing sheets to ensure all corrections have been made as the result of staffing changes such as call outs. The scheduler and service ambassadors were educated by the Director of Nursing or designee on ensuring the staffing hours information is filled out on the daily staffing sheet each day with corrections following staffing changes. Education occurred on 2/7/22. The Director of Nursing or designee will audit the daily staffing sheet for staffing hours 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 months Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. The administrator is responsible for implementing the acceptable plan of	

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	345419	A. BUILDING _____ B. WING _____	C 01/10/2022

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F 732	Continued From page 37	F 732	correction Date of Completion: February 14, 2022	

indicated 3 Licensed Practical Nurses (LPNs) and 7 NAs were scheduled to work on day shift that date. The daily posted nurse summary reported 4 LPNs had provided 32 hours of care and 10 NAs had provided 75 hours of care for that date. The nursing schedule for night shift indicated 4.5 NAs were scheduled to work that date. The daily posted nurse staffing summary indicated 5 NAs had provided 37.5 hours of care that shift.

f. The nursing schedule for 12/13/2021 indicated 3 LPNs were scheduled to work on day shift. The daily posted nurse staffing summary reported 4 LPNs had provided 32 hours of care that shift. The nursing schedule for afternoon shift indicated 8 NAs were scheduled to work. The daily posted nurse summary reported 9 NAs had provided 67.5 hours of care that shift. The nurse schedule indicated 4.5 NAs were scheduled to work night shift on 12/13/2021. The daily posted nurse summary reported 5 NAs had provide 37.5 hours of care that shift.

The Scheduler was interviewed on 1/4/2022 at 10:25 AM. The Scheduler reported she completed the daily posted nurse summary every morning and adjusted it when there were call-outs or other staffing adjustments. The Scheduler reported that she left the facility at 5:00 PM and no one else was responsible for correcting or updating the daily posted nurse summary. The Scheduler reported she did not know if anyone had been instructed to update the daily nurse staffing sheet with changes.

The Director of Nursing (DON) was interviewed on 1/4/2022 at 11:32 AM. The DON reported that the Scheduler should be responsible for updating and correcting the staffing sheet when she is here

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F 732	Continued From page 38 in the building, but no one was assigned that task after 5:00 PM or on the weekends. The DON reported the daily posted nurse summary should accurately reflect the schedule and report the number of licensed and unlicensed staff in the building providing care.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		2/14/22

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F 755	Continued From page 39 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure accurate receiving, dispensing and administration of medications to 1 of 1 residents reviewed for pharmacy services and receipt of medication from the pharmacy (Resident #90). Findings included: Resident #90 was admitted to the facility on 11/24/2021 with diagnoses that included acute TIA (trans ischemic attack) versus subacute stroke of the left frontal white matter, atrial fibrillation (A.fib), hypertension (HTN) and a prosthetic mechanical aortic valve. A review of the hospital discharge summary dated 11/24/2021 revealed that Resident #90 was to receive the following medications while he resided at the facility lisinopril 10 milligrams (mgs) orally (po) daily for HTN, prednisone 20 mgs (2 tablets) po for left knee pain at 7:30 AM for 2 more days, rosuvastatin calcium (crestor) 10 mg po every bed time (q hs), warfarin (coumadin) 2.5 mgs po every day at 6:00 PM, allopurinol (zyloprim) 100 mg tablet po 2 times a day and carvedilol (coreg) 3.125 mg tablet po q hs. Review of the medication administration record (MAR) for Resident #90 dated on 11/24/2021 and 11/25/2021 revealed that he did not receive medications as prescribed because the medications were not available. On 12/29/2021 at 1:25 PM a phone conversation	F 755	F755 F755 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident # 90 no longer resides in the center How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have potential to be affected Measures to be put in place or systemic changes made to ensure practice will not re-occur: Director of Nursing, Unit manager, and designee will conduct audits of medication carts to ensure medications are available per medical doctor order. Any medications not present will be ordered for delivery by pharmacy and medical doctor notified if a dose is missed. Licensed nurses will be educated by Regional Customer Service Representative for Pharmscript Pharmacy or designee on medication administration, process to obtain medications for new admissions and refills, Omnicell use, when and how to best communicate with the pharmacy, and notifications to the provider if medication is not available for immediate administration. Medications for	

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F 755	Continued From page 40 conducted with a family member of Resident #90 revealed in part that she did not understand why the facility did not have the medications ordered for Resident #90 available when he was admitted to the facility. Nurse #10 was interviewed via phone on 12/30/2021 at 1:56 PM. Nurse #10 reported that after a nurse entered medication orders into the electronic medical record (EMR) the orders were sent remotely to the pharmacy. The pharmacy had 2 to 3 delivery times for medications and that the last time she believed was at midnight. Nurse #10 revealed that she explained to Resident #90 that his medications had not arrived by the end of her shift at 10:00 PM on 11/24/2021. Nurse # 10 revealed that she had checked the facility Omnicell (an automated medication storage cabinet used to store medications allowing access to medications needed prior to medication delivery from a pharmacy) dispenser and it did not contain the medications ordered for Resident #90. On 12/30/2021 at 1:08 PM Nurse #8 was interviewed and she reported that on 11/25/2021 at 6:00 AM she met Resident #90 and was not aware that he had not received the medications he was to receive as ordered by the hospital physician. Nurse #8 explained that she was about to check the Omnicell for the medications but Resident #90 was walking up the hall toward the lobby and stated that he was not staying at the facility and his family was coming to pick him up. A review of the medication inventory list present in the Omnicell on 11/24/2021 and 11/25/2021 revealed that it contained lisinopril, prednisone, warfarin, coreg, allopurinol.	F 755	newly admitted residents and new orders are to be obtained from the Omnicell. A list of all meds included available at Omnicell is kept at nurses station. Regional Customer Service Representative for Pharmscript will be notified when medications are not received timely from pharmacy and will follow up on delivery within 24 hours. Medical Director expects himself or his physician extender to be notified when a medication is not available from pharmacy and when the expected delivery of the medication will be Any Licensed Nurse who is not educated by February 14, 2022, will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse, Director of Nursing, or designee during orientation for process of administering and ordering medications How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: DON or designee will audit for new medications and admission medications availability and provider notification 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. The administrator is responsible for implementing the acceptable plan of correction	

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F 755	Continued From page 41 A review of pharmacy medication delivery times revealed that the pharmacy made deliveries 3 times a day during the week and for midafternoon delivery, medications had to be sent to the pharmacy by 9:00AM. For the late evening delivery, orders needed to be received by the pharmacy by 4:00PM and for the overnight delivery medication orders needed to be received by the pharmacy by 9:00 PM. An extended weekday cut off time was available for new admission medications until 2:00 AM if the nurse notified the pharmacy was aware of the new admission by 7:00 PM. A phone interview was conducted with the director of quality at the pharmacy at 10:19 AM on 01/04/2022. The director revealed that any communication between the facility and pharmacy was electronically date and time stamped. She also reported that on 11/24/2021 there had been no communication received from the facility about medications for Resident #90 . Medication orders for Resident #90 were received by the pharmacy at 10:05 PM on 11/24/2021. The facility did not request a medication delivery delay at any time on that date. The director also confirmed that on 11/24/2021 the Omnicell at the facility contained all the medication that was prescribed for Resident #90. The director reveled that when the Omnicell was opened there was an automatic time and date stamp that included the resident name and nurse identifier, but there was no record that the Omnicell at the facility had been accessed on 11/24/2021 or on 11/25/2021 until 11:30 AM. The director went on to explain that if any medications were not available in the Omnicell that the nurse could have called the emergency backup number and the pharmacy	F 755	Completion February 14, 2022	

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F 755	Continued From page 42	F 755		

would have had a local pharmacy deliver the medication immediately.

An interview conducted with the nurse practitioner (NP) at 11:50 AM on 01/04/2022 revealed that she expected that nurse staff use every available resource to obtain resident medication and notify the prescriber of any concerns related to obtaining the medications.

Two attempts to contact the nurse that entered the medication orders for Resident #90 into the EMR were made on 01/04/2022 at 1:03 PM and 2:36 PM there was no response or return call back.

On 01/04/2022 at 2:52 PM the director of nurses (DON) was interviewed and she revealed that on 11/25/2021 she came to the facility as requested by the discharge planner because Resident #90 was signing himself out of the facility against medical advice and that his family member was at the facility and wanted an explanation about Resident #90 not receiving his prescribed medication. The DON stated that she tried to explain the process of ordering medications to the family member and the DON went to the Omnicell at 11:30 AM and removed all the medications ordered for Resident #90 and that all of the medication was present and available for Resident #90. The DON reported that nurses were expected to check the Omnicell for any medication ordered so that there were no missed medications or the nurse was expected to contact the pharmacy to review medication needs and then the prescriber, resident and family if there was a concern that a medication could not be made available as ordered.

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F 755	Continued From page 43 On 01/07/2022 at 10:47 AM a phone interview was conducted with the facility physician (MD) and he revealed that he did not know Resident #90 but on review of the hospital and facility medical records he was aware that the nurse staff did not administer medications to Resident #90 as prescribed and that it was expected that the nurses used all available options to obtain medications.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer 1 dose of a prescribed anticoagulant (warfarin) for 1 of 1 residents reviewed for anticoagulant orders (Resident #90). Findings included: Resident #90 was admitted to the facility on 11/24/2021 with diagnoses that included acute TIA (trans ischemic attack) versus subacute stroke of the left frontal white matter, atrial fibrillation (A.fib), hypertension (HTN) and a prosthetic mechanical aortic valve. A review of the hospital history and physical summary dated 11/21/2021 revealed in part that Resident #90 was to receive warfarin (coumadin) 2.5 milligrams (mgs) orally (po) every day at 6:00 PM for his mechanical aortic heart valve with the goal to maintain his INR (international normalized ratio) at a therapeutic goal range of 2 to 3 and the	F 760	F760 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #90 is no longer a resident of the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents who take warfarin have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Regional Director of Clinical services	2/14/22

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F 760	Continued From page 44 current range of his INR was 2.4. A review of the medication administration record (MAR) dated from 11/24/2021 through 11/25/2021 revealed that Resident #90 had not received the scheduled dose of warfarin at 6:00 PM on 11/24/2021. On 12/29/2021 at 1:25PM a phone conversation conducted with a family member of Resident #90 revealed in part that it was very important that Resident #90 receive his anticoagulant medication as ordered but he missed warfarin dose the night he was admitted and the family member was worried about the health of Resident #90 because he required the warfarin to prevent another stroke. A review of the medication inventory list present in the Omnicell on 11/24/2021 and 11/25/2021 revealed that it contained 8 tablets of warfarin I mg tablets, 5tablets of warfarin 3 mg tablets and 5 tablets of warfarin 5 mg tablets. Nurse #10 was interviewed via phone on 12/30/2021 at 1:56 PM. Nurse #10 reported that after a nurse entered medication orders into the electronic medical record (EMR) the orders were sent remotely to the pharmacy. Nurse #10 revealed that she had not administered warfarin to Resident #90. A phone interview was conducted with the director of quality at the pharmacy at 10:19 AM on 01/04/2022. The director revealed that The Omnicell at the facility did contain 3 different doses of warfarin and that it was not electronically recorded that warfarin was extracted from the Omnicell on 11/24/2021 or 11/25/2021 for	F 760	completed audit on 2/3/22 to identify current residents who have received warfarin medication in the previous 60 days. Licensed nurses will be educated by Regional Customer Service Representative for Pharmscript Pharmacy or designee on medication administration, process to obtain medications for new admissions and refills, Omnicell use, when and how to best communicate with the pharmacy, and notifications to the provider if medication is not available for immediate administration. A list of medications available in the Omnicell is located at each nursing station Medications for newly admitted residents and new orders are to be obtained from the Omnicell. Warfarin specific education to be provided including potential risk associated with missed doses. If Warfarin tablets are scored they are able to be divided amongst the scored line to make a different dose. Any Licensed Nurse who is not educated by February 14, 2022, will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of administering and ordering medications How the facility plans to monitor its performance to make sure that solutions are sustained. DON or designee will audit for new medications and admission medications	

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F 760	Continued From page 45 Resident #90. An interview conducted with the nurse practitioner (NP) at 11:50 AM on 01/04/2022 revealed that she did not know Resident #90 and she was not the practitioner on call on 11/24/2021 or 11/25/2021. The NP reported that the nurse should have reported that Resident #90 did not receive warfarin 2.5 mgs po at 6:00PM on 11/24/2021. On 01/04/2022 at 2:52 PM the director of nurses (DON) was interviewed and she revealed that on 11/25/2021 she came to the facility as requested by the discharge planner because Resident #90 was signing himself out of the facility against medical advice and that his family member was at the facility and wanted an explanation about Resident #90 not receiving his warfarin. The DON reported that warfarin was available in the Omnicell and that it was expected to have been administered to Resident #90 on 11/24/2021 as ordered. On 01/07/2022 at 10:47 AM a phone interview was conducted with the facility physician (MD) and he revealed that he did not know Resident #90 but on review of the hospital and facility medical records he was aware that when Resident #90 was discharged from the hospital on 11/24/2021 he had an INR of 2.4 which was therapeutic and that he was to receive a dose of warfarin every evening at 6:00 PM but had missed the dose scheduled on 11/24/2021. The MD explained that it was the responsibility of the facility nurse staff to notify the prescriber, resident and the family of medication concerns as the facility protocol stated.	F 760	availability and provider notification 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Date of Compliance: 02/14/2022	

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F 761	Continued From page 46	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to dispose of expired medications and unlabeled, opened medications in one of two medication storage rooms (Unit B medication storage room). The facility also failed to dispose of one expired inhalation solution packet; and failed to label one inhalation solution packet with open date in one of five medication carts (Unit A North Hall medication cart).	F 761	F761 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. How facility will identify other resident	2/14/22

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F 761	Continued From page 47 The findings included: A. An observation was conducted on 12/28/21 at 11:00 AM in the medication storage room for Unit B with Nurse #1 present. The medication refrigerator had two opened multi-dose vials of tuberculin purified protein derivative with opened dates as 10/11/21 and one opened multi-dose vial of influenza vaccine with no open date marked on the vial. Nurse #1 removed the medication to be discarded. B. On 12/28/21 at 1:00 PM an observation of the medication cart on Unit A North Hall was conducted with Nurse #3 present. The observation revealed the following: One opened Albuterol Sulfate Nebulization Solution with one opened foil packet dated 10/10/2021 that contained 19 vials of medication with an open date of 10-10-21. One opened foil packet of Ipratropium-Albuterol Solution that contained 19 ampules with no opened date. On 12/28/21 at 11:05 AM an interview was conducted with the Nurse #1. During the interview, Nurse #1 revealed she was not aware of the expired and non-labeled medications found in the medication room refrigerator on Unit B. Nurse #1 indicated that the Staff Development Nurse was responsible for the management of multi-use vials of vaccines and tuberculin solution. 12/30/21 at 1:10 PM a follow up interview was conducted with Nurse #1. She indicated that she	F 761	having the potential to be affected by the same deficient practice. Current residents have the potential to be affected by the alleged deficient practice. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Unit managers and Regional Director of Clinical Services conducted audits of current medication storage rooms, medication rooms, and med carts to ensure expired medications were discarded. The DON or designee to provided facility licensed nurses with education on the labeling and storage of drugs. No designated area to place vials or medications with questionable expiration dates. Undated and expired medications are to be discarded immediately. DON, Nursing administration will conduct reviews of medications in the facility storage rooms, medication rooms, and medication carts for expired medications 3 times a week for 4 weeks, 1 time a week x 8 weeks, and then monthly x 2 months. The facility pharmacist will also review medications carts monthly and report any concerns with labeling and storage of drugs to the Administrator and Director of Nursing. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The results of the audits will be reviewed at the QAPI committee for analysis of any patterns, trends, or need for further systemic changes.	

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	345419	A. BUILDING _____ B. WING _____	C 01/10/2022

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tried to check the medication storage refrigerators when she cleaned the medication storage room on her unit, but denied she checked it daily. Nurse #1 indicated the night shift floor nurses were responsible for checking the labeling and expiration dates in the medication storage refrigerators on their unit.

On 12/28/21 at 1:17 PM an interview was conducted with Nurse #3. She was working on Unit A North Hall and was responsible for the medication cart on this shift. Nurse #3 indicated she was not aware there were medications that were not labeled with an open date, or medications that were expired in her medication cart. She stated she was not certain of the discard date of opened inhalation solutions, but thought it was six weeks after opened.

On 12/29/21 at 8:45 AM an interview was conducted with the Staff Development Nurse (SDN). The SDN stated it was the responsibility of all the nurses to label and monitor open dates and expiration dates on medications. She was unaware of any medications that were not labeled with open dates or expired medications not discarded. The SDN indicated the nurse who administered the initial dose of the multi-use vial should have labeled it with the open date. She also indicated each nurse should observe the open date on all medications before administration and properly discard when expired. The SDN stated opened multi-use tuberculin solution vials and influenza vaccine multi-use vials should be discarded 30 days after opened. The SDN further indicated the monitoring and management of labeling and proper disposal of expired medications was a collective effort of all the nurses.

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On 12/30/21at 8:54 AM a telephone interview was conducted with the Pharmacy Director of Quality (DOQ). The DOQ explained the pharmacy's policy for proper disposal of tuberculin purified derivative vial should be 30 days after opened. She indicated the Flucelvax multi-use vial should have been labeled with the open date when initially used. The DOQ indicated Albuterol Sulfate Nebulization Solution should be discarded 7 days after the foil packet was opened.

On 12/30/21 at 12:45 PM a telephone interview was conducted with the Pharmacy Consultant (PC). The PC stated that she visited the facility once a month. The PC indicated that she was most recently at the facility on the morning of 12/28/21 and performed audits of the medication storage room and the medication carts on Unit A. She revealed tuberculin solution Aplisol derivative should be discarded 30 days after opened. The PC stated that all medications should be labeled with the open date. The PC stated that she found multiple medications that were expired and/or without open dates during her audits at the facility in September, October, November, and December of 2021. The PC stated that she made the nurse manager aware and provided education to the nurses of her findings. The PC indicated she was aware of the facility's practice of storage of medications in the door on the top shelf of the medication room refrigerators for nurse management review. She further indicated that she had advised the facility against this practice on multiple occasions.

On 12/30/21 at 10:25 AM an interview was conducted with the Director of Nursing (DON). The DON stated the nurses were responsible for

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F 761	Continued From page 50 discarding expired medications. She was not aware there were expired medications in the medication storage refrigerator or medication cart. The DON indicated multi-use vials should be labeled with an open date upon the initial use. The DON explained that the facility had a policy and procedure for storage of questionable medications to be placed in the door on the top shelf of the medication storage room refrigerators on each unit. She referred to the designated areas as "butter bowls". She indicated this was the designated areas for storage of medications for nurse management to review the expiration dates. The DON indicated the unit managers were to check the designated areas in the medication storage refrigerators on each unit daily. The DON stated there was no documentation of the discarded medications from the designated areas medication storage refrigerator. The medication storage refrigerators on either unit did not have signage to identify where to place medications not to be used.	F 761		
F 880 SS=E	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. §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:	F 880		2/14/22

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F 880	Continued From page 51 §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 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.	F 880		

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F 880	Continued From page 52 §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 observations and staff interviews the facility failed to perform hand hygiene before donning gloves. One of one dietary staff (Dietary Aide #1) donned gloves without performing hand hygiene to place lids on drinks for meal service during one observation. The findings included: On 12/29/21 at 12:20 PM observations were made in the kitchen during the lunch meal preparation. Dietary Aide #1 walked from from the dish washing station area and consumed a beverage from a cup. After he placed the cup down, he then donned gloves and did not perform hand hygiene after he consumed the beverage. Dietary Aide #1 walked over to food preparation area immediately after donning gloves and placed lids on beverage cups for the residents. On 12/29/21 at 12:49 PM an interview was conducted with the interim Dietary Manager (DM). She stated Dietary Aide #1 was a contracted employee that were working to assist the regular dietary staff. The Dietary Manager revealed she	F 880	F880 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Dietary staff was immediately educated on infection control and proper hand hygiene. How the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents in the center have the potential to be affected. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Dietary staff will be provided a training and review by the Infection Control Preventionist/designee on the centers	

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F 880	Continued From page 53 was not aware of the improper hand hygiene practices of Dietary Aide #1 that occurred during the lunch meal preparation. The DM did not indicate her expectations for proper hand washing technique for dietary staff while working in the meal preparation area. On 12/29/21 at 1:30 PM an interview was conducted with Dietary Aide #1. He stated he was not thinking when he donned gloves without washing his hands and voiced understanding this was an infection control issue. On 12/29/21 at 2:20 PM an interview was conducted with the Administrator. She indicated Dietary Aide #1 was a contracted employee from the same culinary service as the facility. The Administrator stated she expected all dietary employees that work at the facility to adhere to safe food handling and infection control procedures.	F 880	policy for infection control in regard to proper hand hygiene on 02/11/2022. Any dietary staff who do not attend the education will not be allowed to work after the completion date until education is provided. How the facility plans to monitor its performance to make sure that solutions are sustained. Infection Preventionist or designee will complete a twice weekly inspection of staff within the dietary area for one month, and once weekly for an additional month to ensure compliance with provided training on hand hygiene. Completion 02/14/2022	