STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 01/31/22 through 02/04/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 8E5O11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/31/22 through 02/04/22. Event ID # 8E5O11. 2 of the 17 complaint allegations was substantiated resulting in deficiecy.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		3/15/22

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

Electronically Signed | 02/28/2022

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: 1a) remove a black substance from the base of the toilets in 8 of 19 resident rooms in the memory care unit (#103,104, 105,107,108,112,117,122). 1b) failed to repair or replace the cove base molding (a type of trim that is installed along the base of an interior wall where the wall meets the floor that's made of vinyl or rubber and is used to protect the base of a wall from damage) in resident rooms, bathrooms, in 4 of 19 resident rooms (#103,109, 111, 116) and the common area. 1c) failed to replace broken or missing toilet paper dispensers and towel racks in 3 of 19 resident rooms and resident bathrooms (#108,110, 113). 1d) failed to repair a clogged toilet in 3 of 19 resident rooms (#103,110, 112). 1e) failed to repair a leaking commode base in 1 of 19 resident rooms (#122), and repair loose pipes that extended from the back of the toilet	F 584	Franklin Oaks Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Franklin Oaks Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the deficiency is accurate. Further, Franklin Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	

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F 584	Continued From page 2 that attached to the wall in 1 of 19 resident rooms (#103) and failed to ensure the toilet was secured to the bathroom floor (#109, 115, 117) in 3 of 19 resident rooms. 1f) failed to clean or replace the discolored tiles on the bathroom floor surrounding the toilet base (#103). 1g) failed to repair a sink faucet that sprayed water when the cold-water handle was turned on and repair a faucet that did not function and repair a loose sink faucet in 3 of 19 resident rooms (#108, 111, 115). 1h) failed to repair the drywall that was blistered and paint that had peeled away from the wall (room 112) and failed to complete the repair of the drywall at the resident's bedside (#103, 118) and repair missing drywall (#118) and repair a hole in the wall (#117) in 3 of 19 resident rooms. 1i.) failed to repair paint that had peeled away from the ceiling around the air vent in 2 of 19 resident rooms (#113, 115). Findings included. 1a. An observation on 02/01/22 at 1:30 PM revealed 8 of 19 resident rooms had a black substance noted surrounding the base of the toilets in resident rooms that were on the memory care unit (103,104, 105,107,108,112,117,122). 1 of 19 resident rooms on the memory care unit had dark brown stained tile covering the floor around the toilet with dark areas of unknown material around the baseboard in a resident's bathroom (#104). 1b. An observation on 02/01/22 at 1:30 PM revealed the cove base molding in areas throughout the memory care unit in resident rooms and bathrooms were partially intact, the molding had pulled away from the wall in 4 of 19 rooms (room 103, 109, 111, 116), the molding	F 584	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 584 Safe/Clean/Comfortable/Homelike Environment The black substance from the commode base in room # 103, 104, 105, 107, 108, 112,117 and 122 was cleaned by the Housekeeping Director on 2/4/2022. The cove base molding in resident rooms and bathrooms # 103 ,109, 111 and 116 was repaired/replaced by the Maintenance Director on 2/24/2022. The toilet paper dispensers were repaired or replaced, and towel racks were removed in resident rooms and bathrooms # 108, 110, and 113 by Maintenance Staff on 2/24/2022. The clogged commodes in resident bathrooms 110 and 112 were repaired/replaced by Maintenance Staff on 2/4/2022. The leaking commode in resident room #122 was repaired/replaced by Maintenance Staff on 2/4/2022. Room # 103 has been taken out of service until repairs can be made to the loose pipes. Resident rooms # 109, 115 and 117 have been taken out of service until repairs can be made to secure toilets to the floor. The sinks in resident rooms # 108, 111 and 115 were repaired/replaced by Maintenance Staff on 2/25/2022. The drywall in resident room # 112 & 118 was repaired and painted by Hillco Services on 2/25/2022.	

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F 584	Continued From page 3 was missing from the base of the wall which exposed damaged drywall in the common area where residents were gathered to watch TV. 1c. An observation on 02/01/22 at 1:30 PM revealed 3 of 19 resident rooms on the memory care unit had missing parts on the toilet paper dispensers and missing or broken parts on the towel racks in the resident's room and bathrooms (#108, 110, 113). 1d. An observation was conducted on 02/01/22 at 1:30 PM. The toilet in room 112 was clogged with a large amount of feces and toilet paper in the toilet. There was feces noted around the toilet seat and toilet base with foul odor. The toilet in room 110 would fill to the top of the toilet bowl just before overflowing when flushed, and the toilet in room 103 would not flush. 1e. An observation on 02/03/22 at 2:00 PM revealed 1 of 19 resident rooms on the memory care unit had a wet area on the floor around and behind the base of the toilet which appeared to be leaking from the toilet base in a resident's bathroom (#122), in 1 of 19 resident rooms the plumbing pipes that extended from the back of the toilet and attached to the wall were loose (#103), and the toilets were not secured to the floor and could be moved or pushed to one side in 3 of 19 resident rooms (#109, 115, 117). 1f. An observation on 02/03/22 at 2:00 PM revealed 1 of 19 resident rooms on the memory care unit had deep dark brown stains and discolored tiles around the toilet base and the cove base was pulled away from the wall in the resident's bathroom, the toilet did not flush, a large area of spackle (a putty used to fill holes, or	F 584	Resident Room #103 & 117 have been taken out of service until drywall can be repaired. Resident Room #113 & 115 have been taken out of service until the damaged ceiling around the air vent can be repaired and painted. 100% observation of the facility to include all resident's rooms, to include rooms # 103, 104, 105, 107, 108, 109, 110, 111, 112, 113, 115, 116, 117, 118 and 122 was completed on 2/25/2022, by the Housekeeping Director and the Maintenance Director to ensure all areas and rooms are in good repair. Work orders were completed on 2/25/2022 by the Administrator and Maintenance Director for notification to Maintenance for any identified areas of concern. The Maintenance Director was in-serviced by the Administrator on 2/4/2022 regarding ensuring rooms are in good repair. An In-service was initiated on 2/24/2022 for all licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers to notify Maintenance of any areas in the facility in need of repair or painting to include resident rooms by completing a work order in TELS system by the Staff Facilitator. In-services will be completed by 3/15/2022. All newly hired license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers will be in-serviced by the Staff Facilitator regarding to notify Maintenance of any areas in the facility in need of repair or	

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F 584	Continued From page 4 cracks in drywall) was observed on the wall at the side of the resident's bed. The toilet pipes connecting the toilet to the wall were loose (#103). 1g. An observation on 02/03/22 at 2:00 PM revealed 1 of 19 resident rooms on the memory care unit had a sink faucet that sprayed water from the top of the faucet when the faucet was turned on (#108) and in 1 of 19 rooms the sink faucet handle did not turn at all when attempts were made to turn the water on (#115), the sink faucet was loose in 2 of 19 resident rooms (#111, 118). 1h. An observation on 02/03/22 at 2:00 PM revealed drywall that was blistered in several areas and paint that had peeled away from the wall on the side of the closet beside the sink in the resident's room (room 112). A large area of spackle (a putty used to fill holes, or cracks in drywall) was observed on the wall at the side of the resident's bed (#103) and spackle on the wall behind bed "B" and the closet base by the sink had missing drywall in room 118. Room 117 had a hole in the wall behind the door of the resident's room that had not been repaired, there were scratched walls on two walls in the resident's room, and spackled areas on the walls. 1i. An observation on 02/03/22 at 2:00 PM revealed 1 of 19 resident rooms on the memory care unit had areas of peeling paint around the ceiling vent (#113, 115). An interview was conducted on 02/01/22 at 1:30 PM with Nurse #1. She stated the Maintenance Director was aware there were issues with the plumbing and the toilets being clogged or	F 584	painting to include resident's rooms by completing a work order in TELS during orientation. The Maintenance Staff & Housekeeping Director will monitor all areas of the facility to include 20 of all resident rooms, to include rooms # 104, 105, 107, 108, 110, 112, 116, 118 and 122 to ensure rooms are in good repair weekly x 8 weeks then monthly x 1 utilizing a Homelike Environment Audit tool and complete a work order in TELS for all identified areas of concerns. The Maintenance Director will immediately address any identified areas of concern during the audit. The Administrator will review the Homelike Environment Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will present the findings of the Homelike Environment Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The Executive QAPI Committee will meet monthly for 3 months and review the Homelike Environment Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 584	Continued From page 5	F 584		

overflowing on the memory care unit. She stated maintenance had unclogged and snaked (tool used to remove clog) the toilets and they would flush okay for a day and not flush other days. She stated it was an ongoing problem, and she didn't know what the root of the problem was that caused the toilets to continue to clog. She stated residents had been known to put objects in the toilets which could cause the toilets to clog. She stated the resident that uses the bathroom in room 112 had not been in the bathroom that morning so therefore the toilet had been clogged most likely since the night shift. She stated she had not placed any work orders regarding the condition of the memory care unit such as the toilets needing repair, the missing and damaged cove base, the drywall repairs that were needed and she was not aware the sink faucets in some of the resident rooms were not functioning. She stated the housekeeping aides cleaned the bathrooms and she was not aware of what the black substance surrounding the toilet base in some of the resident rooms was. She indicated the condition of the drywall, the toilets, the stained floors in the bathrooms, the scratches on the walls in the resident rooms had been like that for a while and maintenance was aware, so she had not placed any work orders regarding those repairs. She was uncertain as to how long the hole had been in the wall in room 117 or how long spackle had been on the walls in the resident rooms.

An interview was conducted on 02/01/22 at 2:34 PM with the Housekeeping Aide #1. She stated she had not had a chance to clean rooms on the memory unit that morning due to being pulled to clean rooms on another unit. She stated she did not miss cleaning the bathroom in room 112, but

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F 584	Continued From page 6	F 584		

knew the toilet was clogged. She stated she typically started her day cleaning the memory care unit. She cleaned all rooms and cleaned all high touch areas daily including bathroom toilets and floors. She indicated she was not aware what the black substance around the base of the toilets was and stated if she observed a clogged toilet, she would get a nurse or nurse aide to unclog the toilet and have the nurse or nurse aid to remove any objects in the toilet then she would go behind the nurse or nurse aid and disinfect the toilet.

An interview was conducted on 02/03/22 at 10:26 AM with the Housekeeping Supervisor. He stated the housekeeping aides should be cleaning the walls, floors, resident bathrooms, and toilets and sanitizing bedside tables and all high touch surfaces daily. He stated he was not aware of a black substance around the toilet base in some of the resident rooms on the memory care unit. He stated he conducted spot checks on the hall to make sure the cleaning was done. He stated the housekeeping aides were trained in blood borne pathogens and should never go find a nurse or nurse aide to unclog a toilet before they cleaned it. He stated it was the housekeeping aide's responsibility to unclog a toilet and make sure the bathrooms were cleaned and sanitized, and if the housekeeping aides had any concerns, they should come get him not the nurse. He stated he expected all rooms to be cleaned daily, and if the housekeeping aid found a toilet that was clogged and needed cleaning it was their responsibility to clean and attempt to unclog the toilet, if they could not do that, he would expect the housekeeping staff to notify him. If the toilet remained clogged, the housekeeping staff should notify the Maintenance Director. He stated housekeeping staff should not place the

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F 584	Continued From page 7	F 584		

responsibility of unclogging toilets on the nurse on the unit without first attempting to unclog the toilets or having him or the Maintenance Director to unclog the toilets. He stated moving forward he would conduct more spot checks to ensure the resident rooms and bathrooms were cleaned properly.

An interview was conducted on 02/03/22 at 11:53 AM with the Director of Nursing (DON). She stated no staff member had reported any concerns to her regarding the condition of the memory care unit. She stated she assisted the nurse aid on the memory care unit today to unclog the toilet in room 112 so that housekeeping would go in and clean it. She indicated it was the responsibility of the Maintenance Director to ensure that the toilets were in working order, and the repairs were made to the drywall.

An interview was conducted on 02/03/22 at 2:44 PM with the Maintenance Director. He stated the facility utilized an electronic work order system (TELS) and staff would either put in a work order or notify him verbally of any concerns or if something needed to be repaired. He stated he checked TELS work orders every morning and any work orders placed in TELS would be addressed. He indicated he did not routinely conduct walk through rounds of the facility to address any maintenance needs and he relied on staff to notify him of any needs through verbal communication or by placing a work order. He stated there were no current work orders placed in TELS regarding leaking or clogged toilets, loose pipes on the toilets, faucets that weren't working in resident rooms on the memory care unit, and there were no work orders or notification

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F 584	Continued From page 8	F 584		

of the black substance found around the toilets, the damaged drywall, and no orders placed to address the concerns with the cove base. He stated he had no way to secure the loose toilet pipes to the wall in the resident bathrooms, but he could replace the pipes if it was pulled off the wall or reattach the pipes if needed. He stated the nurses and nurse aides on the memory care unit had not notified him of the conditions or concerns on the unit. He stated the current work orders in TELS was related to the outside of building and attic but no orders for any work on the memory care unit. He indicated he relied on the staff in the memory care unit to notify him of any concerns so that they could have been taken care of. He stated they called in a plumber that day to address the clogged toilet in room 112 and it was determined to be clogged from a plastic bottle stuck in the pipe

An interview was conducted, and observations were made in the memory care unit with the Regional Services Director on 02/03/22 at 3:00 PM. He stated he was not aware that the walls, toilets, sink faucets, and damaged drywall was in the condition that was observed. He stated he had reached out to the corporate office and as of now they were in the process of making plans to renovate and remodel the entire memory care unit. He stated it was his expectation that the toilets, faucets, condition of the walls and floors within the unit were maintained and kept in better condition.

An interview was conducted with the Administrator on 02/03/22 at 3:30 PM. She stated there had been some issues in the past regarding the plumbing. She stated she was not fully aware of the issues identified during the survey

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F 584	Continued From page 9 regarding the toilets leaking, sink faucets not working in resident rooms, or the condition of the drywall in some of the rooms including the cove base. She stated there had been mention of plans to renovate the memory care unit but that had not occurred yet. She indicated the Maintenance Director, and the Assistant Maintenance Director were responsible for overseeing the repairs needed within the facility.	F 584		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		3/15/22

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F 690	Continued From page 10 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to provide an anchoring device (leg strap) to prevent tension on catheter tubing for 1 of 4 residents reviewed for catheter care (Resident #102). Findings Included: Resident #102 was admitted on 6/30/19 with diagnoses to include urinary retention secondary to obstructive uropathy (condition when the flow of urine is blocked), chronic kidney disease, and hydronephrosis (when a kidney has excess fluid due to backup of urine). The Significant Change Minimum Data Set (MDS) assessment dated 12/29/21 revealed Resident #102 had an indwelling catheter in place for urinary retention secondary to obstructive uropathy. The Care Plan for Resident #102 dated 1/18/22 noted an indwelling catheter present due to urine retention secondary to obstructive uropathy. The interventions included: catheter care per physician orders and/or facility policy. Review of the electronic medical record (EMR) for Resident #102 revealed a physician order	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI On 1/31/2022 an anchoring device was placed on resident #102 by the Nurse Supervisor to ensure the foley catheter was secure. On 1/31/2022 a 100% audit was completed by the Nurse Supervisor, on all affected residents to include resident #102 for ensuring anchoring devices were present per facility protocol. All areas of concern were immediately corrected during the audit by the Nurse Supervisor to include ensuring all residents with catheters had anchoring devices in place. There was no other identified area of concern. On 2/22/2022 an in-service was initiated by the Staff Facilitator with all nursing assistants and nurses regarding all residents with catheters to ensure anchoring devices are intact and present. The in-service will be completed by 3/15/2022. All newly hired nurses and nurse assistants will be in-serviced regarding catheter anchoring devices	

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F 690	Continued From page 11 dated 12/24/21 to ensure catheter is secured and intact daily. An observation of Resident #102 on 1/31/22 at 12:51 PM revealed there was no anchoring device in place to secure her urinary catheter. An interview was conducted on 2/2/22 at 10:43 AM with NA#4. She stated she provided catheter care during the residents ' baths every day. She stated catheters should have a leg strap in place to keep them from getting pulled. An interview was conducted with Nursing Supervisor (NS) on 1/31/22 at 1:10 PM. He stated the urinary catheter should have had an anchoring device (leg strap) in place. He applied a leg strap to Resident #102 ' s right thigh to secure the catheter. An interview was conducted with the Administrator on 2/2/22 at 12:50 PM. She stated she expected urinary catheters to be secured with an anchoring device (leg strap). She stated Resident #102 would remove the leg strap herself at times.	F 690	during orientation by the Staff Facilitator. 100% audit of all residents with catheters will be completed by the Treatment Nurse or designee to include resident #102 utilizing the Catheter Anchoring Device Audit Tool 3 x a week x 4 weeks, then monthly x3 months. The Treatment Nurse or designee will immediately correct during audit any identified area of concern to include replacing the anchoring device or retraining nurses and nurse assistants as needed. The Director of Nursing will review and initial the Catheter Anchoring Device Audit Tool weekly x12 weeks and then monthly on-going to ensure all areas of concern have been addressed. The Director of Nursing will forward the results of the Catheter Anchoring Device Audit Tool to the Executive QA Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will meet monthly and review the Catheter Anchoring Device Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		3/15/22

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F 758	Continued From page 12	F 758		

but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

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F 758	Continued From page 13 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to discontinue PRN (as needed) psychotropic medications within 14 days for 2 of 29 residents in the survey sample whose medications were reviewed, Residents #99 and #95. Findings included: 1) Resident #99 was admitted to the facility on 03/14/21 with diagnoses that included Alzheimer's disease, restlessness and agitation, anxiety, and dementia with behavioral disturbance. Review of a Medicare comprehensive MDS (Minimum Data Set) assessment dated 01/04/22 revealed Resident #99 had severely impaired cognition. During the assessment look back period he had received antipsychotic medication on 7 of the days, antidepressant medication on 5 of the days and antianxiety medication on 2 of the days. Behavioral symptoms not directed towards others occurred on 1-3 days during the assessment period. Review of the physician ordered PRN psychotropic medications prescribed for Resident #99 that exceeded 14 days included: Lorazepam tablet 0.5 MG (Milligrams) give one tablet by mouth every 8 hours as needed for anxiety-started on 01/11/22 and discontinued on 02/02/22; and Seroquel 25 MG give 25 MG by mouth every 12 hours as needed for	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use On 2/2/22, The Assistant Director of Nursing clarified stop date for the PRN Psychotropic Medications for resident #99 and #95. The order was updated in the electronic record. On 2/2/22, The Director of Nursing, Assistant Director of Nursing and Medical Director initiated an audit of all PRN psychotropic medication orders. This audit was to ensure all PRN psychotropic orders have appropriate stop dates per pharmacy and facility guidelines. The Director of Nursing and Assistant Director of Nursing addressed all concerns identified during the audit to include clarifying orders with the physician as indicated to include stop dates. Audit was completed on 2/2/22. On 2/2/22, The DON initiated an in-service with all nurses regarding PRN Psychotropic Medications with emphasis on ensuring medication have appropriate stop dates per pharmacy and facility protocol or physician documentation for continued use past the recommended stop orders. In-services will be completed by the Assistant Director of Nursing by 3/15/22	

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F 758	Continued From page 14 agitation-started on 12/29/21 and discontinued on 01/25/22. In an interview with the ADON (Assistant Director of Nursing) on 02/02/22 at 2:30 PM she stated both the PRN Lorazepam ordered on 01/11/22 and the Seroquel ordered on 12/29/21 should have been discontinued within 14 days of the start date or assessed by the physician and continued for a designated amount of time. She commented since this had come to their attention, they had created an improvement plan and would be auditing medication orders closely. She stated the physicians were now entering their own orders in the computer and she felt this was the problem. In an interview conducted with Physician Assistant #1 on 02/04/22 at 1:15 PM she stated she had attended a training that morning regarding stop dates for PRN psychotropic medications. She reported the physicians began entering their own orders into the computer system 6 months ago and were still learning. She stated it was easy when prescriptions were handwritten to prescribe a PRN psychotropic medication with a stop date by simply writing "x 14 days." She commented it was more difficult when entering the information into the computer because the "duration" tab had to be chosen when entering the order to specify a stop date. She stated the physicians were on a learning curve and needed to do better at entering orders into the computer. 2) Resident #95 was admitted to the facility on 12/19/21 with diagnoses that included dementia with behaviors and insomnia.	F 758	for all currently employed licensed nurses. All newly hired nurses will be in-serviced during orientation by the Assistant Director of Nursing or designee regarding PRN Psychotropic Medications. The Assistant Director of Nursing will review all newly written physician orders for PRN psychotropic medications to include orders for resident #95 and #99 utilizing the PRN Psychotropic Medication Audit Tool, 3 x a week x4 weeks, then monthly x3 months. This audit is to ensure all PRN psychotropic orders have appropriate stop dates per pharmacy and facility guidelines or physician documentation for continued use past the recommended stop orders. The Assistant Director of Nursing or designee will address all concerns identified during the audit to include clarifying orders with the physician as indicated to include stop dates. The DON will review the PRN Psychotropic Medication Audit Tool 3 times a week X 4 weeks then monthly x 3 months to ensure all areas of concern were addressed. The DON will forward the PRN Psychotropic Medication Audit Tool to the Quality Assurance and Performance Improvement Committee monthly for three months. The QAPI Committee will meet monthly and review PRN Psychotropic Medication Audit Tool to determine trends and/or issues that may need further interventions put into place	

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F 758	Continued From page 15 Review of the admission Minimum Data Set (MDS) assessment dated 12/25/21 revealed Resident #95 had severely impaired cognition. Review of the physician orders revealed Lorazepam tablets 0.5 MG (milligrams) for Resident #95, give one tablet by mouth every 12 hours as needed for anxiety and had a start date of 01/11/22 but no stop date. In an interview with the Assistant Director of Nursing (ADON) on 02/02/22 at 2:30 PM she stated the PRN Lorazepam ordered on 01/11/22 should have been discontinued within 14 days of the start date or assessed by the physician and continued for a designated amount of time. She commented since this had come to their attention, they had created an improvement plan and would be auditing medication orders closely. She stated the physicians were now entering their own orders in the computer and she felt this was the problem. In an interview with the Director of Nursing on 02/03/22 at 11:44 AM she stated she and the Medical Director went through all medication orders and discontinued all PRN medications with no stop dates. She stated the providers entered their own orders unless a nurse called and received a phone order. She stated there was a drop-down box in the electronic system that allowed for a set duration on a medication order and indicated that was getting missed. She stated instructions have been posted on how to enter prn orders. In an interview with the Physician Assistant #1 on 02/04/22 at 1:15 PM she stated she had attended a training that morning regarding stop dates for	F 758	and to determine the need for further and/or frequency of monitoring.	

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F 758	Continued From page 16 PRN psychotropic medications. She reported the physicians began entering their own orders into the computer system 6 months ago and were still learning. She stated it was easy when prescriptions were handwritten to prescribe a PRN psychotropic medication with a stop date by simply writing "x14 days." She commented it was more difficult when entering the information into the computer because the "duration" tab had to be chosen when entering the order to specify a stop date. She stated the physicians were on a learning curve and needed to do better entering orders into the computer.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		3/15/22

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F 761	Continued From page 17 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, manufacturer's instructions, and staff interviews the facility failed to remove expired insulin pens from 1 of 3 medication carts reviewed for medication storage. Findings included. During an observation with Nurse #2 on 01/31/22 at 11:00 AM a Lantus insulin injectable pen was observed opened on the medication cart in the memory care unit. The insulin pen had a handwritten opened date of 12/30/21. The manufacturers label directed to discard 28 days after opening. Two Novolog insulin injectable pens were opened with a handwritten opened date of 12/20/21 on Novolog pen #1 and an opened date of 12/26/21 on Novolog pen #2. The manufacturers label directed to discard Novolog insulin pens 28 days after opening. In an interview with Nurse #2 on 01/31/22 at 11:00 AM she acknowledged that the insulin pens were expired and stated Lantus and Novolog insulin pens had a discard date of 28 days after opening. She stated she didn't usually work on the memory care unit and had not checked the expiration dates yet that day. She stated she usually checked insulin expiration dates prior to administering the insulin to the residents. She stated she had not administered insulin from the expired pens that day. An interview was conducted on 02/03/22 at 11:37 AM with the Director of Nursing. She stated the	F 761	F761 Storage of Drugs and Biologicals On 1/31/2022, Nurse #2 removed the expired Lantus injectable pen and Novolog injectable pens #1 and #2 from the medication cart. Nurse #2 retrieved back up insulin that had been reordered from Pharmacy. Nurse #2 was immediately educated regarding expired medication and reordering per policy. On 1/31/2022, 100% audit of all medication carts to include the medication cart on the 100 hall was completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Supervisor. The audit was to ensure no expired medications to include insulin, were not stored in the medication carts. The DON, ADON and Nurse Supervisor addressed all concerns identified during audit to include removal of the expired medication and reordering per policy. On 2/22/2022 a 100% in-service was initiated by the DON with all nurses to include nurse #2 regarding expired medications. This in-service has emphasis on (1) checking for expired insulins (2) appropriately storing insulins per policy and (3) a medication discard grid to include discard dates of insulin after opening. In-service will be completed	

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F 761	Continued From page 18 nurses were expected to check for insulin expirations daily and if the medication was expired it should be removed from the medication cart.	F 761	by 3/15/2022. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation regarding medication storage, expirations, and the medication discard grid. A medication discard list was placed on each medication cart to include, 100 hall, for nurses to utilize as a reference for when medications expire. The ADON, Nurse Supervisor, Staff Facilitator and Unit Managers are responsible for checking all medication carts for expired medications and ensuring any expired medications are removed and reordered. All medication carts will be audited by the ADON, Nurse Supervisor, Staff Facilitator and Unit Managers. This audit is to ensure no expired medications are stored in the medication carts. Using the Medication Audit Tool, 2 times a week x 4 weeks, then monthly x 3 months. Any area of concern will follow with immediate re-education. The DON will review and initial the Medication Audit Tool 2 times a week X 4 weeks, then monthly X 3 months to ensure all areas of concerns were addressed. The DON will forward the Medication Audit Tool to the Quality Assurance and Performance Improvement Committee monthly for three months. The QAPI Committee will meet monthly and review Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/15/22

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F 880	Continued From page 20 (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. §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 record review, observations, and staff interviews, the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines for personal protective equipment (PPE) when a staff member (Maintenance Assistant) was observed entering a quarantine room without wearing gloves and a gown. This was observed for 1 of 27 residents reviewed for COVID-19 infection control practices. Findings Included:	F 880	F880 Infection Prevention & Control The Maintenance Assistant was in-serviced with return demonstration on proper donning and doffing personal protective equipment (PPE) for contact isolation rooms to include hand hygiene by the Director of Nursing on 2/1/2022. On 2/1/2022, the Director of Nursing and Staff Facilitator initiated a care audit with	

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F 880	Continued From page 21 Observation of the Green hall COVID-19 quarantine rooms on 1/31/22 at 12:55 PM revealed signs on the door for all healthcare personnel to follow the Special Airborne Contact Precautions for COVID-19 before entering the room. The instructions read in part to : clean hands before entering room and when leaving the room, wear a gown when entering room and remove before leaving, wear N95 or higher level respirator before entering and remove after exiting, protective eyewear or face shield, and to wear gloves when entering room and remove before leaving the room. PPE including gowns, gloves, and N95 masks were noted to be on the doors of the quarantine rooms. On 2/1/22 at 09:37 AM the Maintenance Assistant was observed entering a quarantine room (room 307) wearing an N95 respirator and protective eyewear. The Maintenance Assistant did not don a gown or gloves prior to entering the room. He exited the room carrying the footboard to the bed. An interview was conducted with the Maintenance Assistant on 2/1/22 at 09:42 AM. The Maintenance Assistant stated he didn't think he had to wear a gown or gloves if he wasn't in the room very long. He stated he had not read the sign on the door prior to entering the room. An interview was conducted with the Administrator on 2/2/22 at 12:50 PM. She stated the Maintenance Assistant had told her about the incident when it had occurred. She stated that all staff members should wear the required PPE when entering quarantine rooms.	F 880	return demonstration to ensure that all staff were wearing appropriate PPE in contact isolation rooms to include donning, eyewear, mask, gown, gloves prior to entering isolation room, as well doffing gloves, and preforming hand hygiene prior to exiting isolation room. The Unit Managers and Staff Development Coordinator will address all concerns identified during the audit to include education of the staff. On 2/22/2022, the Director of Nursing and Infection Control Preventionist initiated a PPE Competency Validation with all staff regarding PPE to ensure that all staff were wearing appropriate PPE in contact isolation rooms to include mask, eyewear, gown, gloves as well doffing gloves, and preforming hand hygiene prior to exiting isolation room. In-services will be completed by 3/15/2022. All newly hired staff will be in-serviced by the Staff Development Coordinator during orientation regarding PPE Donning and Doffing/Handwashing with return demonstration. The Unit Managers, Infection Preventionist, Assistant Director of Nursing and Staff Facilitator will observe 10 staff/resident care interactions weekly x 4 weeks then monthly x 1 month to include all shifts and weekends utilizing the PPE Quarantine Audit Tool. This audit is to ensure staff are utilizing appropriate PPE to include gown, N95 mask, eye shield and gloves per facility protocol and following recommendations for quarantine precautions. The Staff Facilitator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 22	F 880	address all areas of concern during the audit to include providing use of appropriate PPE and/or re-education of staff. The DON will review and initial the PPE Quarantine Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing will forward the results of the PPE Quarantine Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The QAPI Committee will meet monthly x 3 months and review the PPE Quarantine Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	