STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		8/18/22

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

Electronically Signed | 08/14/2022

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to provide and maintain documentation of the annual staff training of the (EP) plan and failed to conduct an additional full-scale exercise that was either community-based or individual, facility based or a tabletop exercise as part of their EP plan. The findings included: A review of the facility ' s EP plan revealed: A. No documentation of the annual staff training of the EP plan. B. No evidence of an additional full-scale exercise that was either community-based or individual facility-based exercise or a tabletop exercise in the last 12 months. On 7/21/22 at 9:28 AM, the Maintenance Director was interviewed. He stated he just started working at the facility and did not know if annual training on the EP plan was completed. He stated he knew there was some type of drill and would try to locate that information. On 7/21/22 at 9:29 AM, an interview was conducted with the former Maintenance Director. He stated there were a couple of drills, including	E 001	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. E 001 1. Corrective action for resident(s) affected by the alleged deficient practice: On 8/10/2022, the facility completed training on the facility□s Emergency Preparedness Plan. The training also included an Emergency Evacuation training pertaining to the facility□s biggest risk, a tornado or potential high winds. The Emergency Preparedness Manual has been updated with the current training and educational information. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 8/10/22, the Administrator and Quality	

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E 001	Continued From page 2 a sprinkler head burst in January 2022, conducted last year but no training was done because they could never set it up, there was too many people coming in and out. On 7/21/22 at 9:45 AM, documentation of the burst sprinkler was provided. The Maintenance Director stated he could not locate any other evidence of training or drills. On 7/21/22 at 11:42 AM, an interview was conducted with the Administrator. He stated he just started this month and annual training and should be conducted with all staff annually on the EP plan and the required exercises should be completed.	E 001	Assurance team reviewed the Emergency Preparedness Plan and training material pertaining to a tornado/high winds to be included in the training program. The training material was accurate and up to date for the current year 2022. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: The Administrator conducted training to staff, including contractors on the Emergency Preparedness Plan. Training was also given on the Emergency Evacuation procedures for a tornado or high wind scenario. This training will be completed annually and discussed as part of the QAPI Meeting. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the E001 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The Administrator or designee will monitor for compliance to validate the employees understanding of the Emergency Preparedness training program. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing will be reviewed at the weekly Quality Assurance	

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E 001	Continued From page 3	E 001	Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 8/18/22	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 07/17/22 through 07/21/22. Event ID# 5CXB11. Immediate Jeopardy wa identified at: CFR 483.10 at tag F580 at a scope and severity (J). CFR 483.25 at tag F684 at a scope and severity (J). CFR 483.45 at tag F756 at a scope and severity (J). The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy for tag F684 began on 07/13/22 for Resident #46 and was removed on 07/21/22. Immediate Jeopardy for tags F580 and F756 began on 07/14/22 and was removed on 07/21/22. An extended survey was conducted. 38 of the 59 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3)	F 553		8/11/22

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F 553	Continued From page 4 §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to invite cognitively intact residents to participate in the planning of the residents' care plan for 2 of 3 residents	F 553	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in	

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F 553	Continued From page 5 (Resident #60 and #4) reviewed for participation in care planning. The findings included: 1. Resident #60 was admitted to the facility on 10/1/2019 with diagnoses that included hemiplegia, atrial fibrillation, atherosclerotic heart disease and abnormal posture. A review of the comprehensive annual minimum data set (MDS) dated 6/29/2022 revealed Resident #60 was cognitively intact for decision making. A review of a care plan meeting note dated 4/20/2022 documented a care plan meeting invitation for Resident #60's family member was mailed and invited the family member to attend on 5/4/2022. An interview was conducted with Resident #60 on 7/18/2022 at 9:25 a.m. and she revealed she had not been invited to participate in a care plan meeting and she was not sure what a care plan meeting was at the skilled nursing facility. On 7/19/2022 at 4:35 p.m. an interview was conducted with the MDS coordinator, and she revealed the facility process for care plan meetings was to invite the family of a resident via mail and invite a resident on the day of the care plan meeting. She added that the meeting would take place in the fine dining room and if the resident was not out of bed at the time of the care plan meeting, the meeting would take place without the resident and the individual members of the care plan meeting would be expected to meet with the Resident after the care plan	F 553	compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F553 RIGHT TO PARTICIPATE IN PLANNING CARE Corrective Action: Resident #60: Care plan meeting scheduled for August 18th, 2022. Invitation hand delivered to resident and invitation also mailed to resident□s representatives. Resident #4: Care plan meeting scheduled for August ¿¿¿¿¿18th, 2022. Invitation hand delivered to resident and invitation also mailed to resident□s representatives. Identification of other residents who may be involved with this practice: All current cognitively intact residents, have the potential to be affected by the alleged practice. On 8/9/2022 through 8/10/2022 an audit was completed by the Social Worker, Mini Data Set Support nurse, to ensure that current cognitively intact residents had been invited to participate in the planning of their care. Each current cognitively intact resident was asked if they were invited to participate in the planning of	

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F 553	Continued From page 6 meeting to tell them what had been discussed during the meeting. When asked to demonstrate the documentation of the most recent care plan meeting for Resident #60 a care plan signature form dated 5/4/2022 was provided that read: quarterly care plan meeting was conducted on 5/4/2022 and care plan invitation was sent on 4/20/2022 to the resident representative. Those in attendance were listed as: the social worker, activity director, treatment nurse, MDS nurse, and dietary manager. The Resident was not included on the list. The MDS nurse added that since COVID the care plan meetings had not taken place at the bedside, and she was not certain if the individual members had covered their portions of the care plan meeting with the Resident after the meeting because nothing was documented. She stated a change to the current care plan meeting system should occur to include invitations being sent to cognitively intact residents with a care plan meeting note that included documentation of the invitation, the subjects covered, and any updates that need to occur. She added it was her expectation that all residents that are cognitively intact understand what the care plan meeting was and that it was their right to participate. 2. Resident #4 was originally admitted to the facility on 12/5/18 and re-admitted on 8/9/21. The quarterly minimum data set (MDS) dated 4/18/22 indicated Resident #4 was cognitively intact. A review of the facility's records revealed an invitation to Resident #4's care plan meeting was mailed to the resident's responsible party on 5/25/22 for the meeting date of 6/15/22. There	F 553	their care. If the resident responded with a response of no, then the facility scheduled a care plan meeting and invitation was hand delivered and also mailed to resident□s representatives. Out of the 80 current residents, 19 residents had not been invited to participate in the planning of the resident□s care plan. Each of the 19 residents received an invitation of the scheduled care plan meeting which we be held by 8/18/2022. Each invitation was hand delivered to them, and also mailed to their resident representative. This was completed on 8/10/2022. Systemic Changes: On 8/10/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators, MDS Support Nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Director of Nursing. The education focused on: The resident has the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the	

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F 553	Continued From page 7 was no documentation available indicating Resident #4 was invited to her care plan meeting. The care plan signature form dated 6/15/22 did not include the Resident #4's signature indicating the resident was not in attendance to her care plan meeting. During an interview on 7/18/22 at 11:48 a.m., Resident #4 stated that she was not aware of a care plan meeting to discuss her care. She revealed she had never been invited to any care plan meetings but would like to have been invited. On 7/19/22 at 4:35 p.m., the MDS Nurse stated that she mailed the invitations to the care plan meetings to the residents' responsible parties/families 1-2 weeks prior to the care plan meeting date. If the resident was not up and out of bed at the time of the meeting, the team would conduct the meeting and then each participant will go to the resident's room individually to meet with the resident. She added that the resident would be allowed to give input and the resident's signature obtained. She stated there was no signed medication review or care plan review to demonstrate it was covered with the resident. She added that a tweak to the system should occur to include any resident that was their own responsible party with a cognition status greater than 12 ensuring the resident understood what he/she was invited for and documentation of the meeting that includes the resident's signature, invitation documentation, and documentation of the subjects covered in the meeting with the resident.	F 553	effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This in service was completed by 08/11/2022. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will interview 5 cognitively intact residents to ensure that they have been invited to participate in the planning of their care. This will be done on weekly	

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F 553	Continued From page 8	F 553	basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 8/11/2022	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review, the facility's interdisciplinary team failed to assess and document the ability of a resident to self-administer medications for 1 of 1 resident (Resident #58) who was observed to have medications at bedside. Findings included:	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of	8/18/22

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F 554	Continued From page 9 Resident #58 was admitted to the facility on 6/20/22 with diagnoses that included, in part, end stage renal disease and diabetes. The admission Minimum Data Set assessment dated 6/26/22 revealed Resident #58 was cognitively intact. Physician (MD) orders were reviewed and included an order dated 7/11/22 for Tums Ultra (calcium carbonate antacid), 1000 milligrams; give three tablets by mouth with meals. Further review of the medical record revealed no assessments or orders were completed for the self-administration of medications. An observation and interview were conducted with Resident #58 on 7/17/22 at 12:16 PM. A plastic medication cup that contained three Tums tablets was observed within the resident's reach on the overbed table. During an interview with Resident #58, she stated Medication Aide #1 (MA #1) gave the tablets to her late in the morning after she had already eaten her breakfast and since she was supposed to take them with meals, she told MA #1 she would take them with her lunch. Resident #58 did not think she had been assessed by the facility to self-administer medications. On 7/18/22 at 9:59 AM an interview was completed with MA #1. She explained when she gave medications, she typically watched the resident swallow the medication before she left the room. MA #1 recalled she had administered medications to Resident #58 on 7/17/22 and said when she attempted to give the resident the Tums tablets the resident told her she wasn't	F 554	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F554 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #58 the medication was administered on 07/20/2022 by the assigned nurse. On 08/01/2022, resident #58 was assessed by the nursing team for self-administration of medications. Resident indicated she had no desire to self-administer medications. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 08/01/2022, the Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nurses (ADON), and Unit Support Nurse, completed an observation of 100% of all current resident rooms to ensure there were no unsecured medications at the bedside. Results: There were no medications observed at the bedside. On 08/01/2022, the DON, SDC, ADON, and Unit Support Nurse, initiated interviews with residents that were cognitively intact with BIMS of 13-15 regarding their desire to self-administer medication. Results: There were no residents who desired to self-administer their medications.	

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F 554	Continued From page 10 going to take them at that time since she had already eaten her breakfast. MA #1 said she left the medication at the resident's bedside so she could take them later in the day when Resident #58 was ready for them. MA #1 added she knew she was not supposed to leave medications at the bedside but thought since it was "just Tums" and Resident #58 did not have a roommate, that it was okay to leave them for the resident to take later in the day. During an interview with the Long Term Care Unit Manager on 7/20/22 at 9:17 AM, she explained when a nurse or medication aide gave medications to a resident, they watched the resident swallow the medications before they left the room. She stated Resident #58 had not been assessed as being able to self-administer medications and the medication aide should not have left the Tums at the bedside. The Corporate Nurse was interviewed on 7/20/22 at 10:42 AM and stated the facility had self-administration assessments available if a resident requested permission to self-administer medications.	F 554	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/25/2022 the DON and SDC began education of all Full Time, Part Time, PRN licensed nurses (Registered Nurses and Licensed Practical Nurses) and medication aides including agency staff on facility policy related to self -administration of medication process. Education will be completed by 08/18/2022. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correcton is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Monitoring will be completed using the F554 Quality assurance tool. The Director of Nurses or designee will monitor compliance of the medication self-administration process and that no other meds are at bedside if the resident has not been assessed for	

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F 554	Continued From page 11	F 554	self-administration. Monitoring of 6 resident rooms will be completed on various days of the week and shifts to assure compliance with the self-administration of medication policy. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to	F 558	F558	8/18/22

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F 558	Continued From page 12 place a resident's call light within reach to allow for the resident to request staff assistance if needed for 2 of 5 residents (Resident #65 and Resident #41) reviewed for accommodation of needs. Findings included: 1. Resident #65 was admitted to the facility on 7/3/18 with diagnoses that included, in part, chronic obstructive pulmonary disease and hypertension. The annual Minimum Data Set (MDS) assessment dated 7/8/22 revealed Resident #65 had moderately impaired cognition. She required extensive assistance with bed mobility and was totally dependent for assistance with transfers. The comprehensive care plan, updated 7/18/22, included a focused area of risk for falls. A care plan intervention included, "ensure that call light is within reach." On 7/17/22 at 3:08 PM, Resident #65 was observed in her bed. The call light was on the nightstand to the right of the resident's bed and the cord was draped over the side of the nightstand. During an interview with Resident #65 on 7/17/22 at 3:10 PM, she reported she was unable to reach the call light and stated when staff came into the room she told them to put the call light cord within her reach. During an observation of Resident #65 on 7/18/22 at 4:18 PM, she was awake and in bed. The call light was observed behind the resident and underneath her pillow. Upon interview with Resident #65 on 7/18/22 at 4:19 PM, she said	F 558	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/10/2022, the Director of Nurses (DON) initiated an observation of resident□s rooms. The call device was in reach of resident #41. On 08/10/2022, the DON initiated an observation of resident□s rooms. The call device was in reach of resident #65. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. On 08/10/2022 the DON initiated walking rounds to audit 100% of all resident rooms for reachable access to a call device. Any residents who didn't have their call device in reach, had their call device placed within their reach.	

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F 558	Continued From page 13 she could not reach the call light since it was behind her and underneath her pillow. An interview was completed with Nurse #13 on 7/21/22 at 2:12 PM, during which she stated Resident #65 used her call light and made her needs known to staff. She explained when she provided care, before she left a resident's room, she made sure the call light was within reach of the resident or clipped to the resident's bed or clothing. During an interview with the Interim Director of Nursing (DON) on 7/21/22 at 2:56 PM, he stated staff were educated that call lights were supposed to be in reach of the residents. 2. Resident #41 was admitted to the facility on 5/9/19 with diagnoses that included, in part, diabetes and hypertension. The quarterly MDS assessment dated 6/17/22 revealed Resident #41 had severely impaired cognition. She required extensive assistance with bed mobility and was totally dependent for assistance with transfers. The comprehensive care plan, updated 6/3/22, included a focused area of activities of daily living. A care plan intervention included, "encourage me to use call light to call for assistance." On 7/17/22 at 12:46 PM, Resident #41 was observed in her bed. The call light cord was in the nightstand drawer to the left of the resident's bed and the push button hung outside of the drawer. Resident #41 attempted to reach the call button from her bed but was unable to reach over far enough to push the call light button.	F 558	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/18/2022, the DON initiated observation rounds that will be completed by Nurse managers and department managers and include observation of call devices to ensure they are in reach of residents for accommodation of needs. On 08/10/2022, the DON and Staff Development Coordinator (SDC) began education of all full time, part time, PRN, licensed nurses (Registered Nurses and Licensed Practical Nurses), Medication Aides, and Certified Nursing Assistants (CNA) including agency staff on facility policy of assuring that residents have reachable access to a call device used to notify staff when they need assistance. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

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F 558	Continued From page 14 During an observation of Resident #41 on 7/19/22 at 9:39 AM, she was in bed and engaged in simple conversation. The call light was observed draped over the nightstand drawer and Resident #41 demonstrated she was unable to reach the call light. An interview was completed with Nurse #7 on 7/21/22 at 11:35 AM, during which she stated Resident #41 used her call light and made her needs known to staff. She explained it was the responsibility of the nurse aides to place the call light within reach of the resident when they were finished providing care. During an interview with the Interim DON on 7/21/22 at 2:56 PM, he stated staff were educated that call lights were supposed to be in reach of the residents.	F 558	Quality assurance audits will be completed by the Director of Nurses or designee to monitor the that residents are able to access a reachable call device to request staff assistance using the F558 Quality Assurance Tool. Monitoring of 6 resident rooms will be completed on various days of the week and shifts to assure compliance with the call bell policy. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance with facility policy on call bell process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		8/18/22

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F 561	Continued From page 15 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to honor a resident ' s choice to receive a shower twice a week for 1 of 4 residents reviewed for choices (Resident #35). The findings included: Resident #35 was admitted to the facility on 6/3/22 with diagnoses of, in part, depression, pressure ulcer to sacral region and neuromuscular dysfunction of bladder. An admission Minimum Data Set assessment dated 6/8/22 revealed Resident #35 had intact	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561	

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F 561	Continued From page 16 cognition. He required extensive assistance of 2 people for transfers and minimum assistance for bathing. Resident #35 was non-ambulatory. A review of the care plan dated 6/23/22 revealed a focus on activities of daily living self-care performance deficit related to deconditioning and interventions for help with activities of daily living. A review of the shower schedule for Resident #35 revealed he was to receive a shower on Sunday and Tuesday on 7PM-7AM shift. On 7/17/22 at 11:50 AM, an interview was conducted with Resident #35. He stated he had not had a shower since he was admitted on 6/3/22 and his hair was dirty and needed to be washed. He stated they tried to give hm one once, but he got very dizzy when he sat up and had to be put back into the bed. He stated he would be willing to try using a shower stretcher or a reclining chair if available. He stated he had received bed baths. On 7/20/22 at 8:45 AM, an interview was conducted with Nursing Assistant (NA) #2. She stated she worked with Resident #35 on 7/17/22 and did not give him a shower because the resident was unable to sit up. On 7/20/22 at 8:53 AM, an interview was conducted with NA#3. She stated every room had its own shower and the facility did not have a shower stretcher. NA#3 added there was at least one other resident that was unable to sit up and used a reclining wheelchair to receive a shower. On 7/21/22 at 10:51 AM, the Director of Nursing (DON) was interviewed. He stated if a resident	F 561	1. Corrective action for resident(s) affected by the alleged deficient practice: A corrective action was obtained when resident #35 received a shower on 07/21/2022. On 08/13/2022, resident was interviewed on his preferences for his shower. Resident□s preferences were updated in the resident□s task. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 08/13/2022 the Registered Nurse Supervisor (RN) completed resident interviews on 100% of all current residents to identify if they have a preference of when they wished to take their shower. Any residents who requested a preference of when they wished to be showered had their task updated to reflect their preference. This was completed on 08/13/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/12/2022, the Quality Assurance Nurse Consultant educated the Director of Nurses (DON) on residents right to choose when they wish to shower. This education included how to update the resident record to reflect their preference. On 07/25/2022, the DON and the Staff	

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F 561	Continued From page 17 had a medical concern where they were unable to sit up to receive a shower, management should be notified so alternates could be put in place so residents can receive showers. He added that just because there was another wheelchair in the facility the reclined, did not mean it was appropriate for Resident #35. He stated physical therapy might need to get involved to determine the appropriate chair for Resident #35. The DON did not know why that had not been done yet.	F 561	Development Coordinator (SDC) began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (CNA□s), including agency staff on self-determination including resident preferences of when they wish to shower and promoting residents□ rights. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F561 Self Determination Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to assure that residents preference and choices are being honored in regards to showers. This will include auditing 6 residents on various days and shifts to ensure corrective action is initiated as	

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F 561	Continued From page 18	F 561	appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		7/22/22

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F 580	Continued From page 19 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner, and Medical Director interviews, the facility failed to notify the physician of critical laboratory results. Resident #46's blood sugar was critically low at 37 milligrams/deciliter (mg/dl) on 07/14/22 and critically low at 25 mg/dl on 07/15/22 through laboratory work. These results were not acted on by the facility, daily insulin continued, and no further blood sugars were done. This deficient practice occurred for 1 of 2 residents reviewed for notification of changes (Resident #46). Immediate jeopardy began on 7/14/22 when nursing staff failed to identify critical laboratory	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F580	

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F 580	Continued From page 20 results resulting in the lack of physician notification and was removed on 7/21/22 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The findings included: Resident #46 was readmitted to the facility on 7/12/22 with diagnoses including Covid, left hip fracture and insulin-dependent diabetes mellitus. He was prescribed insulin with regular blood sugar checks during previous admission. A hospital discharge summary dated 7/12/22 included an order for long-acting basal insulin 20 units daily (long-acting means insulin enters bloodstream in 2-4 hours from administration time and can last up to 24 hours in the body) and blood sugar test strips to check blood sugars four times daily as directed. The hospital discharge summary dated 7/12/22 also included an order to draw a complete blood count (CBC), basic metabolic panel (BMP), and thyroid stimulating hormone (TSH) on 7/13/22. Resident #46's bloodwork dated 7/14/22 showed a critical low blood sugar value of 37 milligrams/deciliter (mg/dl) (normal level 70-99 mg/dl). Per laboratory report, multiple, unsuccessful attempts were made to contact the facility staff about this critical value. This result was released to the electronic medical record and faxed to the facility on 7/14/22 at 3:28pm. Review of the medical record for Resident #46	F 580	1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #46 is deceased therefore no corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected. On 07/19/2022, the Nurse Consultant completed an audit of 100% of all current resident□s lab values to identify if there were any alert lab values that were not communicated to the Nurse Practitioner or Medical Provider for the last 60 days. The audit revealed eleven alert lab values were reviewed. Six alert lab values had provider notification upon receipt. The Director of Nurses and the Assistant Director of Nurses immediately notified the Medical Director and Individual providers on 07/20/2022 of the five required alert lab values that were not previously communicated at the time of the lab results. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on Critical Labs and changes in condition including critical labs or signs/symptoms of hypoglycemia. Staff	

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F 580	Continued From page 21 revealed there was no documentation the physician was notified of the critically low blood sugar on 7/14/22. Review of Resident #46's MAR showed that blood work was drawn again on 7/15/22 and there was no documentation that it was done on 7/14/22. Resident #46's laboratory results for the BMP dated 7/15/22 showed a critical low blood sugar of 25 mg/dl. Per report, this critical result was called Nurse #9 on 7/15/22 at 5:02pm by lab technician #1. This result was released to the electronic medical record and faxed to the facility on 7/15/22 at 5:02 pm. Review of the medical record for Resident #46 revealed there was no documentation the physician was notified of the critically low blood sugar on 7/15/22. During an interview with lab technician #1 on 7/19/22 at 2:47 pm, he stated that he was never able to reach a staff member on 7/14/22 to relay critical sugar results but did reach Nurse #9 on 7/15/22 and informed him of the current critical level of 25 (mg/dl), as well as the previous result of 37 (mg/dl) at that time. He also stated that, if he was unable to reach a staff member by phone, per the laboratory policy, he would release the results to the facility's system to be flagged and would continue to try to reach the facility by phone. During an interview with Nurse #9 on 7/19/22 at 9:45 am, he stated that he had no recollection of ever receiving a phone call from the lab regarding critical lab results for Resident #46. When asked	F 580	were educated on how critical labs are received, to promptly notify the physician and/or on call of all critical labs, document notification in the electronic record, and to notify the resident and RP of changes in condition including critical labs or signs/symptoms of hypoglycemia. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 07/22/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that notification of changes is being completed for critical lab results using the F580 Quality Assurance Tool. Monitoring of 100% of the critical lab results will be completed weekly to assure compliance with notification of changes. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance with facility policy on notification of changes. Reports will be presented to the weekly QA committee by the Director of	

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F 580	Continued From page 22 about critical lab results, he stated he would contact the on-call provider, get any orders that may be needed, and then place a printed copy of the results in the doctor's folder for him/her to sign off on when they come into the facility next. He again stated that he did not recall receiving any phone calls about any critical results on 7/15/22. During an interview with the Nurse Practitioner on 7/19/22 at 3:35 pm, the state surveyor notified her of critical lab results from 7/14/22 and 7/15/22. She stated that she was not aware of any critical blood levels for Resident #46. She stated the phone number to contact the on call doctor was available 24 hours a day. She also stated, along with immediate verbal notification, there was a folder where the staff will put any critical lab value reports for her to review upon next visit to the facility. She also stated that she was in the facility on 7/18/22 and there were no critical levels in her folder for her to review. During an interview with the Medical Director on 7/19/22 at 5:02 pm, the state surveyor notified him of critical lab results from 7/14/22 and 7/15/22. He stated the phone number to contact him or whomever was on call for him is available 24 hours a day. He also stated, along with immediate verbal notification, there was a folder where the staff will put any critical lab value reports for him or his staff to review upon next visit to the facility. The Administrator was notified of immediate jeopardy on 7/20/22 at 11:16am. The facility provided a credible allegation of immediate jeopardy removal dated 7/20/2022.	F 580	Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 07/22/2022	

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F 580	Continued From page 23 Credible Allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident # 46 was deceased on 07/17/2022 and is no longer a resident of the facility. On 07/19/2022, the Nurse Consultant completed an audit of 100% of all current resident's lab values to identify if there were any alert lab values that were not communicated to the Nurse Practitioner or Medical Provider for the last 60 days. The audit revealed eleven alert lab values were reviewed. Six alert lab values had provider notification upon receipt. The Director of Nurses and the Assistant Director of Nurses immediately notified the Medical Director and Individual providers on 07/20/2022 of the five required alert lab values that were not previously communicated at the time of the lab results. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on Critical Labs. Staff were educated on how critical labs are received, to promptly notify the physician and/or on call of all critical labs, document notification in the electronic record, and to notify the resident and RP of the critical labs.	F 580		

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F 580	Continued From page 24 The DON will ensure that any licensed staff who has not completed the in-service training on 7/19/2022, will not be allowed to work until the critical lab training is completed. The critical lab in-service will be incorporated into the new employee facility orientation program for both facility and agency licensed staff. On 7/19/2022, the DON was notified of the responsibility to ensure the critical lab in-service will be incorporated into the new employee facility orientation program for both facility and agency licensed staff by the Clinical Nurse Consultant. Date of IJ removal 7/21/2022 The credible allegation of immediate jeopardy removal was verified on 7/21/22 as evidenced by onsite validation through record review, and staff interviews. A review of facility in-service materials titled "Critical Lab Education", "Changes in Condition", and "Preventing Errors on Admission" were reviewed for content. Staff were interviewed to validate in-service completion on signs and symptoms of hypoglycemia and physician notification regarding critical lab results. The DON, assistant DON, the floating DON, and the corporate nurse met with all floor nurses and assessed all current residents to identify any signs and symptoms of hypoglycemia. Per their assessment, no current residents were identified having any signs and symptoms of hypoglycemia. The immediate jeopardy was removed on 7/21/22.	F 580		
F 584 SS=B	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,	F 584		8/18/22

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F 584	Continued From page 25	F 584		

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, 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:

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F 584	Continued From page 26 Based on observations and resident and staff interviews, the facility failed to provide a homelike environment for 1 of 3 rooms reviewed on the 300 hall (Room 321) and failed to maintain a clean living environment for 2 of 8 residents (Resident #8 and Resident #58) reviewed for environment. The findings included: 1. Resident #35 (Room 321) was admitted to the facility on 6/3/22. On 7/17/21 at 12:16 PM, an observation of Resident #35 ' s room revealed two wheelchairs, 1 walker, 1 oxygen concentrator in the room. Bed linens were thrown over a chair across the room, the shelving area contained several personal items that were placed there haphazardly, and the nightstand contained multiple food items and other items that did not appear neat. On 7/17/21 at 12:16 PM, during an interview with Resident #35, he agreed his room was messy and was like that since he moved from his other room. He added one wheelchair was his and he did not use oxygen and did not know why the oxygen concentrator was in his room. On 7/19/22 at 10:10 AM, an interview was conducted with Housekeeper #1 who stated she did not put items away in the resident rooms, nursing assistants were responsible for that. On 7/19/22 at 10:15 AM, an interview was conducted with NA #3 who stated the nursing assistants should put the resident ' s belongings away on admission and remove unused items and equipment.	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584 1. Corrective action for resident(s) affected by the alleged deficient practice: On 8/1/2022, the privacy curtains for residents #8 and #58 were removed and replaced with clean privacy curtains by the housekeeping staff. Also the room of resident #35 was emptied of all items not related to the resident□s care. The room was then cleaned to include sweeping and mopping of floor, cleaning of the nightstand, over bed lighting and windowsills. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: 100% audit of all rooms in the facility was completed by the administrative staff on 8/11/2022 to ensure that all rooms were free of clutter and cleaned according to policy. Any rooms not cleaned properly were reported to Environmental Director and cleaned per policy.	

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F 584	Continued From page 27 2. Resident #8 was admitted to the facility on 1/24/22. The quarterly Minimum Data Set assessment dated 5/5/22 indicated Resident #8 was cognitively intact. An observation of Resident #8's room on 7/17/22 at 11:46 AM revealed dark colored stains on the bottom half of the privacy curtain. During an interview with Resident #8 on 7/17/22 at 11:47 AM, she said she wasn't sure how long the privacy curtain had been stained and added, "It's been there long enough." Observations of Resident #8's room on 7/19/22 at 10:25 AM and 7/21/22 at 2:01 PM revealed dark colored stains on the bottom half of the privacy curtain. During an interview with Housekeeper #2 on 7/21/22 at 2:30 PM, she shared when she cleaned residents' rooms she made observations of the privacy curtains and if they were stained or soiled, she removed the curtain and sent it to the laundry to be washed. She said there were extra privacy curtains in the laundry room that could be hung up if a resident's curtain was stained and sent to the laundry department. On 7/21/22 at 2:01 PM, an observation of Resident #8's privacy curtain was completed with the Environmental Services Director. During an interview with the Environmental Services Director on 7/21/22 at 2:03 PM, he said housekeeping staff were responsible to make observations of the privacy curtains when they	F 584	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: All housekeepers were re-educated by the Environmental Director by 8/1/2022 on cleaning rooms according to the General Housekeeping Guidelines policy. Audits: The Environmental Director or designee will complete weekly audits using the Housekeeping QA Audit Tool to ensure that resident rooms are being cleaned according to policy. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. This Housekeeping QA Audit Tool will be completed weekly reviewing 2 rooms on each hall to identify any rooms that have not been cleaned according to policy. This above audit will be completed weekly times 4 weeks then monthly times 3 months or until resolved by Quality Assurance (QA) Committee. Reports will be presented to the monthly QA committee by the Administrator or Environmental Services Director to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Support Nurses, Therapy, HIM, and Dietary Manager.	

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F 584	Continued From page 28	F 584	Date of Compliance: 8/18/2022	

cleaned residents' rooms. If the curtain was observed to be stained or soiled, the housekeeper removed the curtain and sent it to the laundry to be washed and then hung back up in the resident's room. The Environmental Services Director confirmed dark colored stains were present on the privacy curtain in Resident #8's room and said staff should have removed the curtain and sent it to the laundry department to be cleaned.

An interview was completed with the Administrator on 7/21/22 at 3:29 PM. He said privacy curtains should be free of stains and cleaned as needed.

3. Resident #58 was admitted to the facility on 6/20/22. The admission Minimum Data Set assessment dated 6/26/22 indicated Resident #58 was cognitively intact.

An observation of Resident #58's room on 7/17/22 at 12:16 PM revealed dark colored stains on the bottom half of the privacy curtain.

During an interview with Resident #58 on 7/17/22 at 12:17 PM, she said she had trouble seeing, but that the privacy curtain had been in her room since she was admitted to the facility.

Observations of Resident #58's room on 7/19/22 at 4:21 PM and 7/21/22 at 2:10 PM revealed dark colored stains on the bottom half of the privacy curtain.

During an interview with Housekeeper #2 on 7/21/22 at 2:30 PM, she shared when she cleaned residents' rooms she made observations of the privacy curtains and if they were stained or

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F 584	Continued From page 29 soiled, she removed the curtain and sent it to the laundry to be washed. She said there were extra privacy curtains in the laundry room that could be hung up if a resident's curtain was stained and sent to the laundry department. On 7/21/22 at 2:10 PM an observation of Resident #58's privacy curtain was completed with the Environmental Services Director. During an interview with the Environmental Services Director on 7/21/22 at 2:12 PM, he said housekeeping staff were responsible to make observations of the privacy curtains when they cleaned residents' rooms. If the curtain was observed to be stained or soiled, the housekeeper removed the curtain and sent it to the laundry to be washed and then hung back up in the resident's room. The Environmental Services Director confirmed dark colored stains were present on the privacy curtain in Resident #58's room and said staff should have removed the curtain and sent it to the laundry department to be cleaned. An interview was completed with the Administrator on 7/21/22 at 3:29 PM. He said privacy curtains should be free of stains and cleaned as needed.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum	F 641	The statements made on this Plan of Correction are not an admission to and do	8/11/22

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F 641	Continued From page 30 Data Set (MDS) assessment in the areas of weight loss and medications for 2 of 33 residents reviewed (Resident #15 and Resident #24). The findings included: 1. Resident #15 was admitted to the facility on 4/1/122 with diagnoses of, in part, edema, congestive heart failure and dementia. The Admission Nursing Assessment dated 4/1/22 revealed Resident #15 ' s weight on admission was 272.4 pounds. A medical record review revealed the following weights for Resident #15: 4/9/22 271.6 4/10/22 250 5/10/22 236.8 A quarterly MDS dated 5/13/22 revealed Resident #15 had moderately impaired cognition, was independent with meals after set up and weighed 238 pounds. The MDS was code "No" for weight loss. On 7/19/22 at 3:25 PM, the MDS Nurse was interviewed. She stated she didn ' t code the weight loss because she didn ' t think the weight was accurate. On 7/21/22 at 3:00 PM, an interview was conducted with the Director of Nursing. He stated their intent was to ensure the MDS assessment was coded appropriately. 2. Resident #24 was admitted to the facility on	F 641	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 ACCURACY OF ASSESSMENTS Corrective Action: Resident # 15: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [5/13/2022] was modified. Resident # 24: Resident Minimum Data Set (MDS) assessment (Admission Assessment,) with Assessment /Reference Date (ARD) [5/27/2022] was modified. Identification of other residents who may be involved with this practice: All current residents who have weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and all current residents who receive medications administered subcutaneously during the Mini Data Set (MDS) 7 day look back for assessment reference date(s) have the potential to be affected by the alleged practice.	

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F 641	Continued From page 31 5/21/22. His cumulative diagnoses included arthritis. The resident did not have a diagnosis of diabetes. The resident ' s Electronic Medical Record (EMR) revealed his medication orders included 20 milligrams (mg) / 0.4 milliliters (ml) adalimumab (a medication which may be used to treat rheumatoid arthritis) injected subcutaneously one time a day every 14 days with a start date of 5/24/22. A review of Resident #24 ' s May 2022 Medication Administration Record (MAR) revealed the resident received one injection of adalimumab on 5/24/22 in accordance with the medication order. The May 2022 MAR did not indicate the resident received insulin. Resident #24 ' s admission Minimum Data Set (MDS) dated 5/27/22 reported the resident received one injection of any type during the 7-day look back period. The MDS also indicated Resident #24 received one insulin injection during this 7-day look back period. An interview was conducted on 7/19/22 at 3:07 PM with the facility ' s MDS Nurse. During the interview, the MDS Nurse was asked to review the Medication section of Resident #24 ' s admission MDS dated 5/27/22. Upon review of both the resident ' s MDS and his EMR, the MDS nurse stated, "It (the injection) was (adalimumab). He did not receive insulin." The MDS nurse confirmed Resident #24 ' s MDS should not have indicated he received an injection of insulin. An interview was conducted on 7/21/22 at 3:00 PM with the facility's Interim Director of Nursing (DON). During the interview, the inaccuracy of the MDS for Resident #24 ' s medication was	F 641	On 8/10/2022 through 8/11/2022 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have weight loss of 5% or more in the last month or loss of 10% or more in last 6 months were coded correctly in section K0300:Weight loss of the Mini Data Set (MDS) .Out of a total of 94 assessments, 3 assessments were modified to reflect accurate data for Section K0300 Weight loss. 3 MDS assessments were modified due to inaccuracy. On 8/10/2022 through 8/11/2022 an audit was completed by the MDS Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents receiving medications administered subcutaneously were coded corrected in Section N0350:Insulin of the Mini Data Set (MDS) . 0 of MDS assessment were modified due to inaccuracy. This was completed on 8/11/2022. Systemic Changes: On 8/11/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Director of Nursing. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 32 discussed. When asked, the Interim DON stated, "It is our intent to ensure the MDS is coded appropriately according to the category of the medication specified."	F 641	Section N: 0350 insulin. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. Review the resident□s medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Determine if the resident received insulin injections during the look-back period. Count the number of days insulin injections were received and/or insulin orders changed. Section K0300: Weight Loss. Loss of 5% or more in the last month or loss of 10% or more in last 6 months. 5% weight loss in 30 days; Start with the resident□s weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident□s current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight. 10% weight loss in 180 days. Start with the resident□s weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident□s current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight. This in service was completed by 8/11/2022. Any Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive	

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	345039	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 641	Continued From page 33	F 641		

in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Monitoring:

To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that Section N: 0350 Insulin and Section K0300 Weight Loss is coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.

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F 641	Continued From page 34	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, hospital and facility record reviews, the facility failed to accurately transcribe a medication order identified for 1 of 6 residents (Resident #24) reviewed for medications administered during the med pass observations. The transcription error resulted in Resident #24 receiving three - 81 milligram (mg) aspirin tablets instead of one tablet daily over a period of 15 days. The findings included: Resident #24 was admitted to the facility on 5/21/22 from a hospital. His cumulative diagnoses included a recent history of multiple fractures. A review of the resident ' s Hospital Discharge Summary included a discharge medication list. This list included the following: 81 milligram (mg) Enteric Coated (EC) aspirin to be administered as one tablet by mouth twice daily for 6 weeks per orthopedics recommendations; then resume once daily. Resident #24 ' s admission orders for the facility	F 658	Date of Compliance: 8/11/2021 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. Corrective action for resident(s) affected by the alleged deficient practice: A corrective action was obtained for resident #24 on 07/20/2022, when the aspirin order was corrected. The Nurse Practitioner was made aware of the alleged deficient practice by the Unit Support Nurse on 07/20/2022. 2. Corrective action for residents with the	8/18/22

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F 658	Continued From page 35	F 658		

were dated 5/21/22. These orders included one - 81 mg EC aspirin tablet to be administered by mouth two times a day for antiplatelet for 6 weeks with a start date of 5/22/22 and end date of 7/3/22 (scheduled for administration at 9:00 AM and 5:00 PM daily). The end date of this order was 42 days or 6 weeks after its start date. A second order was also input into the resident ' s Electronic Medical Record (EMR) on 5/21/22 for one - 81 mg EC aspirin tablet to be administered by mouth one time a day for antiplatelet with a start date of 7/3/22.

The resident ' s May 2022 and June 2022 Medication Administration Records (MARs) revealed he received one - 81 mg EC aspirin tablet administered by mouth two times a day from 5/22/22 to 6/22/22. This order was discontinued on 6/22/22 and a new medication order was input into his Electronic Medical Record (EMR) for 81 mg (EC) aspirin to be administered as one tablet by mouth every 12 hours for antiplatelet for 6 weeks with a start date of 6/22/22 and an end date of 8/3/22 (scheduled for administration at 8:00 AM and 8:00 PM daily). The medication order for one - 81 mg EC aspirin tablet to be administered by mouth one time a day for antiplatelet with a start date of 7/3/22 was re-ordered on 6/22/22.

Resident #24 ' s June 2022 and July 2022 MARs revealed the resident continued to receive one - 81 mg EC aspirin administered by mouth every 12 hours from 6/22/22 through the date of the review (7/17/22). Additionally, Resident #24 received one - 81 mg EC aspirin administered by mouth one time a day initiated on 7/3/22 and scheduled for administration at 9:00 AM daily. Both of the medication orders for the

potential to be affected by the alleged deficient practice.
All residents in the facility who take medications have the potential to be affected.

On 08/01/2022, the Director of Nurses (DON), reviewed 100 % of all new admissions from July 19 □ August 1, 2022 to identify that the orders had been transcribed accurately including orders for accuchecks monitoring. There were no orders for accuchecks that required corrections.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:

Education:

On 07/25/2022, the DON and the Staff Development Coordinator (SDC) began education of all Full Time, Part Time, and as needed (PRN) Licensed Nurses; Registered Nurses (RN), Licensed Practical Nurses (LPNs) including agency staff on the admission orders process and medication transcription including having one nurse to enter the admission orders and a second nurse to verify the admission orders including transcribing the orders correctly and not omitting any new orders.

Additionally, On 07/25/2022, the DON initiated education to the Nurse managers including the Minimum Data Set (MDS) Nurse, SDC, and Unit Support Nurses on

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F 658	Continued From page 36 administration of aspirin were active orders and ran concurrently through the date of the review (7/17/22). Therefore, Resident #24 received a total of 3 tablets of 81 mg EC aspirin from 7/3/22 through 7/17/22. A medication pass observation conducted on 7/17/22 at 10:43 AM revealed Resident #24 received two - 81 mg tablets of aspirin. The review of his medication orders revealed there were two current orders for 81 mg aspirin (one order initiated on 6/22/22 and a second order with a start date of 7/3/22). An interview was conducted on 7/19/22 at 10:27 AM with a corporate floating Director of Nursing (DON) who served as the facility ' s Interim DON from 2/16/22 - 5/23/22. During the interview, the float DON confirmed Resident #24's current medication orders included two - 81 mg aspirin tablets to be given in the morning and one - 81 mg aspirin tablet to be given each evening (a total of 3 tablets daily). She reported upon review of the orders, the aspirin should have been initiated as one - 81 mg EC aspirin tablet administered twice daily for six weeks, then reduced to one tablet given once daily thereafter. The float DON also reported she reviewed the resident ' s EMR and consultation reports. She did not identify the presence of any new orders or recommendations to suggest the initial admission orders for the aspirin had been changed. A telephone interview was conducted on 7/19/22 at 3:56 PM with the Nurse Practitioner (NP) who cared for Resident #24. During the interview, the error identified with the resident ' s aspirin was discussed. The NP reported the facility notified her of this medication error and she had	F 658	the above education of admission order process and medication transcription and on completion of a QA check to verify that all new admissions orders were entered correctly and not omitting any new orders. The QA check will be completed in the clinical meeting attended by the DON, SDC, MDS Nurse, and the Unit Support nurses. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F658 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The DON or designee will monitor for compliance with monitoring of transcribing new orders from all sources including admissions and consult orders including any new orders for aspirin. Reports will be presented to the weekly Quality Assurance committee	

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F 658	Continued From page 37 requested staff review Resident #24 ' s consultations to be sure there were no new orders from orthopedics to change the original time frame for twice daily dosing of his aspirin. No change in the orders were found. She confirmed Resident #24 ' s current orders should have included only one - 81 mg aspirin tablet daily at this time. A telephone interview was conducted on 7/20/22 at 2:20 PM with Nurse #2. Nurse #2 was identified as the nurse who input the revised orders for Resident #24 ' s 81 mg EC aspirin on 6/22/22. When asked, Nurse #2 reported she could not recall any details about inputting the orders. An interview was conducted on 7/20/22 at 3:55 PM with the facility ' s Interim DON. During the interview, the DON reported no new aspirin orders had been identified for Resident #24. The DON stated he would concur that the duplication of aspirin orders for this resident appeared to be a transcription error.	F 658	by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and family interviews the facility failed to provide activities of daily living (ADL) assistance for a resident (Resident #22) that was dependent on staff to receive a shower and nail care in 1 of 5	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	8/18/22

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F 677	Continued From page 38 residents reviewed for ADL care. The findings included: Resident #22 was admitted to the facility on 1/5/2018 with diagnoses that included dementia, cerebral infarction, and aphasia. A review of the quarterly Minimum Data Set (MDS) dated 5/25/2022 revealed Resident #22 had severe cognitive impairment with no rejection of care and required total assistance of one staff member with personal hygiene and bathing. A review of Resident #22's care plan dated 5/30/2022 revealed a focused area for ADL self care performance deficit with interventions that included Resident #22 required staff assistance with bathing and personal hygiene. An observation was conducted of Resident #22 on 7/17/2022 at 12:11 p.m. lying in bed with long fingernails that had dark brown debris under each nail. Her hair was observed to be greasy and stuck to her head and uncombed. An interview was conducted with Resident #22's responsible party (RP) on 7/17/2022 at 3:33 p.m. and she revealed when she visits her mother in the evening, she frequently finds her mother with hair greasy and unwashed and she does not believe her mother receives a shower on a consistent basis. She added the last shower she was aware of was greater than two weeks ago and that was the first one in over three months to her knowledge. She stated the nursing assistants would conduct a bed bath instead of a shower and could not wash her mother's hair in the bed.	F 677	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: On 07/19/2022, a corrective action was obtained for resident #22 when she received a shower and nail care. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 08/13/2022 the Director of Nurses (DON) initiated an audit of 100% of all current residents. This audit was completed to identify any residents who had dirty nails that were not trimmed to the desired length according to their preference. Any resident identified as requiring nail care received nail care. This was completed on 08/13/2022. On 08/13/2022 the DON initiated an audit of 100% of all current residents. This audit was completed to identify any residents	

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F 677	Continued From page 39 An observation was conducted on 7/19/2022 at 6:10 p.m. of Resident #22 lying in bed, with her hair greasy and stuck to her head, uncombed in appearance. Her nails were observed to be long with brown debris underneath each nail. A review of Resident #22's electronic shower task log revealed she had scheduled shower times on Tuesday and Friday, day shift with the following documented showers: Tuesdays: 6/21/2022 no shower given. 6/28/2022 a shower was documented as given. 7/5/2022 no shower given. 7/19/2022 NA #1 documented she provided a shower at 2:48 p.m. Fridays: 7/8/2022 no shower given. An interview was conducted on 7/19/2022 at 6:46 p.m. with the Assistant Director of Nursing (ADON) present at Resident #22 bedside and the ADON stated the Resident's nails were too long and dirty underneath and needed to be cleaned. She stated the Resident's hair was greasy and looked like it needed to be washed. An interview was conducted with NA #1 on 7/19/2022 at 6:54 p.m. and she revealed she did not give Resident #22 a shower on 7/19/2022 and the documentation she charted in the electronic medical chart was inaccurate and charted in error. She stated the documentation that revealed she did not give a shower to the Resident on 7/5/2022 was accurate.	F 677	who had greasy hair and required a shower. Any resident identified as requiring a shower had arrangements to receive a shower. This was completed on 08/13/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/25/2022, the DON and the Staff Development Coordinator (SDC) began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (CNA□s), including agency staff on the right to be showered and receive nail care in a manner that is requested, and necessary to maintain grooming. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

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F 677	Continued From page 40 An interview was conducted on 7/19/2022 at 7:16 p.m. with the Director of Nursing (DON) and he revealed it was his expectation that the highest level of care be provided to all Residents. He stated a root cause analysis would need to occur. It was his expectation that the Resident receive nail and hair care as needed, a shower when scheduled, and accurate documentation every day.	F 677	The DON or Designee will monitor compliance utilizing the F677 ADL Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that dependent residents are receiving showers and nail care as a part of their ADL care. This will include auditing 6 residents on various halls to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner, and Medical Director interviews, the facility failed to monitor blood sugar levels for a	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	7/22/22

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F 684	Continued From page 41 resident with insulin-dependent diabetes (Resident #46). The facility administered long acting insulin without monitoring the resident's blood sugar. On 7/14/22, Resident #46's blood sugar was critically low at 37 milligrams/deciliter (mg/dl) and, on 7/15/22, it was critically low at 25 (mg/dl) through laboratory work. These results were not acted on by the facility, daily insulin continued, and no further blood sugars were done. This deficient practice occurred for 2 of 3 sampled residents. Also, the facility failed to assess, notify the physician, and obtain orders to treat an open area on the right lower leg and left lower leg for 1 of 4 residents reviewed for pressure ulcers (Resident #15). Immediate jeopardy began on 7/13/22 when staff gave Resident #46 his first insulin dose without knowing his current blood sugar level and was removed on 7/21/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The facility was also cited at a scope and severity of D for example #2 (Resident #15). The findings included: Resident #46 was readmitted to the facility on 7/12/22 with diagnoses including left hip fracture, Covid-19, and insulin-dependent diabetes mellitus. He was on insulin with regular blood sugar checks during previous admission. A hospital discharge summary dated 7/12/22	F 684	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #46 is deceased therefore no corrective action was required. On 07/19/2022, a corrective action was obtained for resident #15. The Nurse assessed the residents lower leg wound. There was no signs of infection. The resident received a new order for the wound to his lower leg and treatment was completed. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 07/27/2022, the Director of Nurses completed a 100% audit of current residents to ensure that each resident receives treatment and care in accordance with professional standards of practice. There were no corrective actions required. On 07/19/2022, the Nurse Consultant	

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F 684	Continued From page 42 included an order for long-acting basal insulin 20 units daily (long-acting means insulin enters bloodstream in 2-4 hours from administration time and can last up to 24 hours in the body) and blood sugar test strips to check blood sugars four times daily as directed. The hospital discharge summary dated 7/12/22 also included an order to draw a complete blood count, basic metabolic panel, and thyroid stimulating hormone on 7/13/22. The physician's order dated 7/12/22 was insulin degludec 100 unit/milliliter-inject 20 units subcutaneously one time a day for diabetes mellitus. There were no orders for monitoring blood sugar levels. During an interview with Nurse #8 on 7/19/22 at 10:05 am, she stated she completed Resident #46's admission upon arrival. She stated she faxed the hospital discharge medication orders to the pharmacy and then hand-entered the same orders into the computer system which the on-call doctor approved remotely and then the pharmacy filled the order. She stated she was aware a resident on insulin needed regular finger stick blood sugar checks but did not remember whether or not she entered that into the system as he came with a lot of orders that day. She stated she would have entered blood sugar test strips and treatment orders separate from the pharmacy order. Resident #46's medication administration record (MAR) for July 12 - 17, 2022 showed no current order for fingerstick blood checks. His MAR included documentation that insulin was administered on dates with staff initials.	F 684	completed an audit of 100% of all current insulin dependent diabetic residents to identify if they have orders for accuchecks and if they had any critical glucose labs. This audit was completed on 07/19/2022. The audit identified that 19 of 19 current insulin dependent diabetic residents had orders for accuchecks. No corrective actions were required. Additionally, 0 of 0 current insulin dependent diabetic residents had a critical glucose lab in the last 60 days. No corrective actions were required. All current insulin dependent diabetic residents blood sugars are being monitored as ordered. On 07/19/2022, the Director of Nurses and the nurse management team began an audit of residents who were potentially affected by the noncompliance by completing an audit of all new admissions/readmissions for the month of July 2022, to identify any new admissions/readmissions who are insulin dependent diabetic residents to ensure no orders for accuchecks on the discharge summary were not entered at the time of the admission. The audit was completed on 07/19/2022. The audit identified 18 total admissions. 2 of 18 admissions were insulin dependent diabetics with orders for accuchecks. The 2 admissions identified as insulin dependent diabetics at admission did have orders for accuchecks with blood sugars that are being monitored as ordered. No corrective actions were required. On 7/20/2022, the Director of Nursing and	

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F 684	Continued From page 43 Resident #46's bloodwork dated 7/14/22 showed a critical low blood sugar value of 37 milligrams/deciliter (mg/dl) (normal level 70-99 mg/dl). Per laboratory report, multiple, unsuccessful attempts were made to contact the facility staff about this critical value. Blood work was drawn again on 7/15/22 because no one documented that it was done on 7/14/22. Resident #46's bloodwork dated 7/15/22 showed a critical low blood sugar of 25 mg/dl. Per report, this critical result was called Nurse #9 on 7/15/22 at 5:02pm by the technician who completed the test. During an interview with the lab technician on 7/19/22 at 2:47 pm, he stated that he was never able to reach a staff member on 7/14/22 to relay critical sugar results but did reach Nurse #9 on 7/15/22 and informed him of the current critical level of 25 (mg/dl), as well as the previous result of 37 (mg/dl) at that time. He also stated that, if he was unable to reach a staff member by phone, per the laboratory policy, he would release the results to the system to be flagged and would continue to try to reach the facility by phone. During an interview with Nurse #9 on 7/19/22 at 9:45 am, he stated that he had no recollection of ever receiving a phone call from the lab regarding critical lab results for Resident #46. He stated that he was aware Resident #46 was on insulin. He stated that if blood sugars are done then they are put on the resident's medication administration record. He did not recall doing any fingerstick blood sugar tests on Resident #46 since he was admitted on 7/12/22. He also stated Resident #46 ate "pretty good" while he was there. He added that he was not working on	F 684	Assistant Director of Nurses met with all floor nurses and assessed all current residents to identify any signs and symptoms of hypoglycemia. No current residents were identified having any signs and symptoms of hypoglycemia. No other residents were impacted. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/25/2022 the Director of Nurses and Assistant Director of Nurses began in servicing of all licensed nurses and treatment aides (full time, part time, and prn including agency nurses) on Wound Education including how to manage newly identified wounds for new admissions, readmissions, and any new in-house wounds to ensure that each resident receives treatment and care in accordance with professional standards of practice. On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in servicing all licensed nurses and certified nursing assistants (full time, part time, and prn including agency nurses) on changes in condition which includes hypoglycemia and decreased meal intake. The education also included identifying signs and symptoms of hypoglycemia, assessment monitoring including blood glucose levels, following the diabetic protocol for hypoglycemia, notification of physician of signs and symptoms and documentation of assessment and actions	

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F 684	Continued From page 44 that hall when Resident #46 was admitted and wasn't responsible for entering his initial orders into the system. He was unsure who was assigned to him. Record review showed a Nurse Aide #4 documented that Resident #46 was seen awake and sipping on water and stated he was fine on 7/17/22 at 3:30 am when she made rounds. Multiple attempts to reach Nurse Aide #4 were unsuccessful. On 7/19/22 at 10:15 am, a review Resident #46's meal intake report for 7/13/22-7/16/22 showed he consumed 76-100% of his meal one time and 51-75% one time. All other meals were either < 25% or meal was refused. During an interview with the floating Director of Nursing on 7/19/22 at 3:10pm she stated you should never give insulin without knowing what the current blood sugar level is. She added that how orders are entered into the system and the lack of monitoring blood sugars was something the facility will be working on and will be included in their interdisciplinary meetings. During an interview with the Nurse Practitioner on 7/19/22 at 3:35 pm, the state surveyor notified her that there were no blood sugar checks. She stated the importance of finger stick sugar checks in the presence of insulin and added that you should never administer insulin if you don't know what the current sugar level is. She stated that she was not aware of any critical blood levels for Resident #46. She stated he was newly admitted and she had not had a chance to evaluate him yet. She also stated that she was in the facility	F 684	taken in the medical record. On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on Critical Labs. Staff were educated on how critical labs are received, to promptly notify the physician and/or on call of all critical labs, document notification in the electronic record, and to notify the resident and RP of the critical labs. All critical lab results are currently phoned to the nurse from a lab representative. If the lab is unable to reach the nurse at the facility, the lab representative will contact the on-call nurse to report the critical lab result. The lab manager has been provided the phone number for the nurse on-call phone number by the DON 7/19/2022. The lab representative facility contacts will be updated to include the nurse on-call phone number by the DON on 7/19/2022. The on-call nurse will then be responsible for following up to ensure the following occurs: Physician and/or on call is notified of the critical lab results, documentation of the result in the electronic record, and to notify the resident and RP of the critical labs. On 7/19/2022, the Director of Nursing and Assistant Director of Nurses also began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on the admissions process and review to ensure one nurse enters the orders into the EMR and a second nurse	

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F 684	Continued From page 45 the previous day and there were no critical levels in her folder for her to review. She also stated that she expected all staff, including agency staff, to take care of the residents, for nurses to know current sugar levels prior to administering insulin, and to be able to recognize hypoglycemia signs. During an interview with the Medical Director on 7/19/22 at 5:02 pm, the state surveyor notified her that there were no blood sugar checks. He stated there should be regular finger sticks with all residents who have insulin-dependent diabetes. He stated he was not aware of any critical blood sugar levels. He stated that it was vital to be aware of a resident's blood sugar levels when administering insulin. The Administrator was notified of immediate jeopardy on 7/20/22 at 11:16am. The facility provided a credible allegation of immediate jeopardy removal dated 7/20/2022 at 7:52pm. Credible Allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident # 46 was deceased on 07/17/2022 and is no longer a resident of the facility. On 07/19/2022, the Nurse Consultant completed an audit of 100% of all current insulin dependent diabetic residents to identify if they have orders for accuchecks and if they had any critical sugar labs. This audit was completed on 07/19/2022. The audit identified that 19 of 19 current insulin	F 684	verifies the orders for accuracy. The nurses were also educated on the need to obtain blood glucose monitoring orders for all insulin dependent diabetics and those on diabetic medications. This will be reviewed for all new admissions/readmissions and those with new diagnosis or medication orders for diabetes. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 07/22/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to ensure that each resident receives treatment and care in accordance with professional standards of practice and using the F684 Quality Assurance Tool. Monitoring 6 new admissions of the critical lab results will be completed weekly to assure compliance. Monitoring will be completed weekly x 5 weeks then monthly x 2	

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F 684	Continued From page 46 dependent diabetic residents had orders for accuchecks. No corrective actions were required. Additionally, 0 of 0 current insulin dependent diabetic residents had a critical sugar lab in the last 60 days. No corrective actions were required. All current insulin dependent diabetic residents blood sugars are being monitored as ordered. On 07/19/2022, the Director of Nurses and the nurse management team began an audit of residents who were potentially affected by the noncompliance by completing an audit of all new admissions/readmissions for the month of July 2022, to identify any new admissions/readmissions who are insulin dependent diabetic residents to ensure no orders for accuchecks on the discharge summary were not entered at the time of the admission. The audit was completed on 07/19/2022. The audit identified 18 total admissions. 2 of 18 admissions were insulin dependent diabetics with orders for accuchecks. The 2 admissions identified as insulin dependent diabetics at admission did have orders for accuchecks with blood sugars that are being monitored as ordered. No corrective actions were required. On 7/20/2022, the Director of Nursing and Assistant Director of Nurses met with all floor nurses and assessed all current residents to identify any signs and symptoms of hypoglycemia. No current residents were identified having any signs and symptoms of hypoglycemia. No other residents were impacted. Specify the actions the entity will take to alter the process or system failure to prevent a serious	F 684	months or until resolved for compliance. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 07/22/2022	

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F 684	Continued From page 47	F 684		

adverse outcome from occurring or reoccurring and when the action will be completed.

On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in servicing all licensed nurses and certified nursing assistants (full time, part time, and prn including agency nurses) on changes in condition which includes hypoglycemia and decreased meal intake. The education also included identifying signs and symptoms of hypoglycemia, assessment monitoring including blood sugar levels, following the diabetic protocol for hypoglycemia, notification of physician of signs and symptoms and documentation of assessment and actions taken in the medical record.

On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on Critical Labs. Staff were educated on how critical labs are received, to promptly notify the physician and/or on call of all critical labs, document notification in the electronic record, and to notify the resident and RP of the critical labs. All critical lab results are currently phoned to the nurse from a lab representative. If the lab is unable to reach the nurse at the facility, the lab representative will contact the on-call nurse to report the critical lab result. The lab manager has been provided the phone number for the nurse on-call phone number by the DON 7/19/2022. The lab representative facility contacts will be updated to include the nurse on-call phone number by the DON on 7/19/2022. The on-call nurse will then be responsible for following up to ensure the following occurs: Physician and/or on call is notified of the critical lab results, documentation

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F 684	Continued From page 48	F 684		

of the result in the electronic record, and to notify the resident and RP of the critical labs.

On 7/19/2022, the Director of Nursing and Assistant Director of Nurses also began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on the admissions process and review to ensure one nurse enters the orders into the EMR and a second nurse verifies the orders for accuracy. The nurses were also educated on the need to obtain blood sugar monitoring orders for all insulin dependent diabetics and those on diabetic medications. This will be reviewed for all new admissions/readmissions and those with new diagnosis or medication orders for diabetes.

The DON will ensure that all licensed nurses (full time, part time, and prn including agency nurses) who does not complete the in-service training will not be allowed to work until the training is completed.
This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses (full time, part time, and prn including agency certified nursing assistants and nurses).

Date of IJ removal 7/20/2022

2. Resident #15 was admitted to the facility on 4/1/22 with diagnoses including congestive heart failure, edema and atrial fibrillation.

The quarterly Minimum Data Set (MDS) assessment dated 5/13/22 revealed Resident #15

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F 684	Continued From page 49	F 684		

had moderately impaired cognition and required extensive assistance to total dependence with 1-2 people for his activities of daily living. He had no skin impairment.

A review of the care plan included a focus on incontinence with risk for skin breakdown initiated on 4/23/22 and anticoagulant therapy with an intervention to inspect skin and report abnormalities to nurse.

A Weekly Skin Assessment dated 7/16/22 revealed no new areas.

On 7/17/22 at 11:43 AM, an observation was made of Resident #15 sitting in his wheelchair. A bordered gauze dressing with visible dark drainage was observed to the left lower leg. A hydrocolloid dressing was observed to the right lower leg with a date of 7/14/22. Resident #15 did not know why the bandages were on his legs.

A record review revealed no documentation or orders for the areas to Resident #15 ' s right and leg lower legs.

On 7/18/22 at 11:49 AM, a second observation was made of Resident #15 ' s lower legs. The resident still had the bordered gauze dressing to the left lower leg and the hydrocolloid dressing dated 7/14/22 was still in place to the right lower leg.

On 7/19/22 at 8:25 AM, Nurse #7 stated she didn ' t know anything about the areas or dressings to Resident #15 ' s lower legs. Nurse #7 removed the dressing to the left lower leg and a small open area was observed with a small amount of drainage noted. The right lower leg also had a

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F 684	Continued From page 50 small open area present. A nurses noted dated 7/19/22 at 8:25 AM by Nurse #7 read, "this nurse noted open area to BLE (bilateral lower extremities). Area cleansed with normal saline and dry dressing applied. Physician notified and wound care requested to assess. Orders received." A review of the physician ' s orders revealed an order dated 7/19/22 to clean right and left shin with normal saline, pat dry with gauze, apply triple antibiotic ointment, cover with dry dressing, and secure with tape twice a day until healed. On 7/21/22 at 10:54 AM, an interview was conducted with the Director of Nursing who stated when a resident develops a new area on their skin, the staff member that identifies the area should document it in the medical record with the description, notify the physician and family and put a treatment order in place if needed.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		8/18/22

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F 686	Continued From page 51 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to implement orders by the wound care physician for a resident with a sacral pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident #218). The findings included: Resident #218 was admitted to the facility on 1/22/20 with diagnoses of, in part, spinal stenosis and dementia and expired in the facility on 6/16/22. A progress note by the wound care physician dated 4/27/22 included treatment orders to apply santyl (a debriding agent) and calcium alginate to Resident #218 ' s sacral wound and apply skin prep to the peri-wound. A review of the April 2022 Treatment Administration Record revealed the treatment to the wound was being done but the skin prep ordered to he peri-wound was not listed as a treatment order to be completed. A progress note by the wound care physician dated 5/9/22 indicated the sacral wound deteriorated and was now unstageable due to necrosis (devitalized tissue). Treatment orders included treatment orders to apply Dakin ' s 0.5% (a broad-spectrum antimicrobial cleanser that is gentle to the skin) gauze and a dry dressing. The treatment orders included skin prep to the peri wound (tissue surrounding wound) twice a day.	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #218 discharged from the facility, therefore no corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 08/12/2022 the Director of Nurses (DON) began auditing 100% of the notes from the in house consultant wound MD for the last 4 weeks. This audit consisted of reviewing the wound notes to ensure that all orders and recommendations were carried out in its entirety. Any residents whose orders were not carried out in its entirety, will	

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F 686	Continued From page 52 A significant change in status Minimum Data Set assessment dated 5/18/22 revealed Resident #218 had severely impaired cognition and required extensive to total assistance of 1-2 people with bed mobility, dressing, toileting, hygiene, bathing and eating. Resident #218 was at risk for pressure ulcers, had 1 stage 4 pressure ulcer and received pressure ulcer care. A review of the May 2022 Treatment Administration Record revealed the treatment to the wound bed was being completed but skin prep to the peri-wound was not listed as a treatment order to be completed. On 7/21/22 at 9:31 AM, an interview was conducted with the wound care physician. He stated he was very familiar with Resident #218 as she had a reopened sacral wound that continued to decline due to her condition. He stated when he made wound rounds in the facility, a staff member rounded with him. He stated he measured the wound and stages it if it is a new wound. He stated he then says out loud what the plan is going to be for treatment of the wound so the nurse that rounds with him can take down the orders and the resident knows what is going to be done as well. He stated the skin prep helps the wound dressing stick better and has alcohol in it to help keep the area clean especially with residents that have incontinence. He stated the primary dressing was the most important thing but agreed the skin prep was also important and should have been ordered and being done as well. On 7/21/22 at 10:58 AM, an interview was conducted with the Director of Nursing. He stated there wasn ' t a permanent treatment nurse in the	F 686	have updated orders to reflect required . This audit was completed as of 08/12/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 08/12/2022, the DON and the Staff Development Coordinator (SDC) began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) including agency staff on treatment/services to prevent/heal/pressure ulcers. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F686 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved.	

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F 686	Continued From page 53 facility and they were using agency staff to complete treatments and round weekly with the wound care physician. He stated the nurse that rounds with the wound care physician should have implemented all his orders.	F 686	Audits will occur on various shifts and days of the week. This will include auditing 6 residents on various days and shifts to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to remove an air mattress from a resident ' s bed after a fall which caused a resident to sustain another fall for 1 of 5 residents reviewed for accidents (Resident #218). The findings included: Resident #218 was admitted to the facility on 1/22/2020 with diagnosis of dementia.	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	8/18/22

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F 689	Continued From page 54 A quarterly Minimum Data Set (MDS) assessment dated 1/30/22 revealed Resident #218 had severely impaired cognition and required extensive assistance with bed mobility and total dependence for transfers and toileting. Resident #218 was non-ambulatory and had no falls. A review of Resident #218 ' s care plan dated 2/25/20 and revised on 3/30/22 included a focus on increased risk for falls related to confusion and a history of falls. Interventions included discontinue air mattress dated 3/11/22 and replace mattress dated 3/14/22, hi-low bed dated 3/14/22 and fall mats dated 3/14/22. A nurse ' s note dated 3/10/22 at 5:46 PM read, "resident observed laying on back on floor beside bed and beside dresser. No injuries noted upon initial assessment." A Fall Repot dated 3/10/22 revealed Resident #218 was observed laying on back on floor by bedside dresser and bed. Alert and verbal. No apparent injuries noted. The Fall Report indicated Resident #218 ' s medical record and medications were reviewed, care plan updated, and room inspection completed. Root cause was determined to be the air mattress and intervention listed was remove air mattress. A work order was submitted on 3/11/20 at 10:00 AM by Nurse #11 to remove air mattress from Resident #218 ' s bed. A nurse ' s note dated 3/13/22 at 7:17 PM by Nurse #10 read, "at 3:10 PM, nurse was called to the room of resident by nursing assistant. Nurse found resident lying face down on the right side of	F 689	deficiencies cited have been or will be corrected by the dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #218 is discharged from the facility, therefore no corrective action is required.. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 08/01/2022, the Director of Nurses (DON), Staff Development Coordinator (SDC), and Unit Support Nurse initiated an audit of the falls from the last 14 days from 07/19 □ 08/01/2022. This audit consisted of reviewing falls to ensure the intervention was carried out by physically observing that the intervention is in place if indicated. This audit was completed on 08/01/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/25/2022, the DON and the SDC Nurse initiated Post fall education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), full time, part time, and PRN staff including agency staff on the post fall process.	

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F 689	Continued From page 55 her bed. No injuries were noted to residents back, hips and lower extremities. Resident was log rolled onto a flat sheet to supine position and nurse noted a hematoma to right forehead and discoloration to right eye, skin tears to left hand and bruising to knees. On call physician gave order to send resident to emergency department. Air mattress was removed from bed and replaced with a regular mattress. A Fall Report dated 3/13/22 revealed resident was found on floor beside bed, slid off air mattress. Medical record and medications reviewed; care plan updated. Root cause was determined to be displaced air. Interventions were to place mats beside bed. A review of the Emergency Department record dated 3/13/22 indicated Resident #218 was brought in by emergency medical services for an unwitnessed fall at the facility. Has bruising and contusion to her right forehead. Vital signs within normal range. Computed tomography was completed of head and facial bones and spine with no acute fracture or dislocation and no acute intracranial abnormality found. X-rays to femur, tibia/fibia and pelvis showed no fracture. Resident #218 was not admitted to the hospital. Resident #218 expired in the facility on 6/16/22. On 7/20/22 at 2:22 PM, an interview was conducted with Nurse #12 who was the nurse that worked with Resident #218 on 3/10/22 when she fell out of the bed. She stated she could not recall Resident #218 at all and could not recall if the air mattress was removed from the bed on 3/10/22.	F 689	On 08/12/2022, the Quality Assurance Clinical Nurse Consultant educated the DON on the following topics using the Falls Review Nurse Manager Education: " Ensuring that fall interventions are entered into Kardex, task, or care plan timely if indicated. " Ensuring that the action of removal or addition of falls interventions are put into place timely with observation if indicated. The DON will educate any nurse managers or nurse support staff who assist with the falls investigation process using the Falls Review Nurse Manager Education. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that fall interventions	

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F 689	Continued From page 56 On 7/20/22 at 3:24 PM, an interview was conducted with Nurse #10. She stated when Resident #218 fell on 3/13/22, the air mattress was still on the bed because the resident slid off it. She stated Resident #218 was very thin and Nurse #10 didn ' t think she had enough weight for the air mattress to be effective. She was unaware of the previous intervention to remove the air mattress. On 7/21/22 at 8:48 AM, an interview was conducted with the Former Maintenance worker who stated he could not recall if the air mattress was removed from Resident #218 ' s bed after the fall on 3/10/22. He stated there was a box at the nurse ' s station that work orders were put in and he picked those up 1-2 times a day. He stated if it was something related to a fall, he was on top of that and there was a daily stand-up meeting and falls were discussed. He added if the work request was put in on a Friday (3/11/22), he may not have gotten to it until Monday because he did not work on the weekends. On 7/21/22 at 11:03 AM, an interview was conducted with the Director of Nursing. He stated he wasn ' t at the facility in March when Resident #218 ' s falls occurred. He stated there was a daily stand-up meeting where falls have been discussed and if an intervention like removing an air mattress needed to be done, that would be discussed. He could not explain why the air mattress was still on the bed on 3/13/ 22 after the fall on 3/10/22 and that it should have been removed.	F 689	are in place and carried out timely using the F689 Quality Assurance Tool. Monitoring of 6 residents with falls will be completed weekly to assure compliance with falls interventions. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		8/18/22

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F 692	Continued From page 57 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with Registered Dietician (RD), and staff, the facility failed to implement a high calorie nutritional supplement, as recommended by the RD for a resident with a stage 4 pressure ulcer identified as underweight on admission. The resident continued to lose weight the following month which resulted in severe weight loss that was greater than 5% for 1 of 6 residents reviewed for nutrition (Resident #35). The findings included: Resident #35 was admitted to the facility on 6/3/22 with diagnoses including pressure ulcer of sacral region and depression.	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692	

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F 692	Continued From page 58 Resident #35 was ordered a regular diet on 6/3/22. A dietary assessment dated 6/7/22 revealed Resident #35 was admitted on a regular diet with thin liquids. The current by mouth oral intake was noted as adequate at 50-75%. The resident had multiple wounds. An admission Minimum Data Set assessment dated 6/8/22 revealed Resident #35 was cognitively intact, independent with meals, was 74 inches tall and weighed 136 pounds, did not have any swallowing disorders, and had not lost weight. The assessment did not indicate any nutritional approaches were in place. Resident #35 had a stage 4 pressure ulcer that was present on admission. A note by the Registered Dietician (RD) dated 6/14/22 at 1:39 PM read, in part, "underweight BMI (body mass index). Tolerates regular diet, fair intake. Patient declined RD recommended tube feeding in hospital to assist to improve high protein intake. Recommend provide nutrition supplement to meet nutrition needs. Start Med Pass 2.0 (a high calorie, high protein nutritional supplement) 90 milliliters by mouth three times a day to provide an additional 540 kilocalories and 23 grams of protein". The Medication Administration Record (MAR) for June 2022 revealed the Med Pass 2.0 90 milliliters three times a day was not on the MAR. Review of Resident #35 ' s weights documented in the electronic health record were 136.2 pounds on 6/12/22 and 127.4 pounds on	F 692	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, a corrective action was obtained and completed on 07/17/2022. The Registered Dietitians recommendations were reviewed by the physician on 07/17/2022 and approved. The Staff Development Coordinator (SDC) entered the approved new order from the Registered Dietitians nutritional recommendation into the resident□s electronic medical record (EMR). 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 08/11/2022, the Director of Nurses (DON) completed an audit of all nutritional recommendations for July 2022 that were received from the Registered Dietitian. This audit consisted of reviewing the nutritional recommendations to ensure the provider has reviewed them and that orders were written into the (EMR) if approved by the provider. No deficient findings were found at the time of the audit. 3. Measures /Systemic changes to	

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F 692	Continued From page 59 7/11/22. A note by the RD dated 7/15/22 at 8:02 PM read, in part, 6.6 percent weight loss x 30 days. Recommend provide nutrition supplement to meet nutrition needs. Start Med Pass 2.0 90 milliliters by mouth three times a day." A review of the July 2022 physician ' s orders revealed the order for Med Pass 2.0 90 milliliters three times a day was entered on 7/17/22. On 7/17/22 at 11:52 AM, Resident #35 was interviewed. He stated he was a chef at a nice restaurant and the food in the facility was terrible up to a couple of days ago. He stated no one had ever asked him about food likes/dislikes. On 7/17/22 at 11:52 AM, an interview was conducted with the Dietary Manager. She stated she came back to work at the facility on 7/3/22 and menus changed 7/6/22 due to a change in the food caterer. She stated she had not spoken to Resident #35 about food preferences, and she did not think food preferences were maintained. She added she could find no record of food preferences for Resident #35. She stated he got a daily menu that was placed on his breakfast tray, and he could choose what he wanted to eat the following day. On 7/20/22 at 10:17 AM, the RD was interviewed. She stated she visited Resident #35 on 6/14/22 and identified him as high risk because of medical conditions and wounds. She added the Med Pass to meet increased nutritional needs. She stated when she made recommendations, she emailed them to the Administrator, the Director of Nursing and the Dietary Manager. She	F 692	prevent reoccurrence of alleged deficient practice: On 08/12/2022 in-service education was initiated by the Quality Assurance Nurse Consultant to the DON. Topics included: " The Registered Dietician will Complete Nutritional assessments for residents to identify nutritional risk (significant weight change, wounds, enteral feedings, dialysis residents, etc.), nutritional declines, and opportunities to improve nutritional status. Registered Dietician nutritional recommendations are to be reviewed and approved by physician services. If nutritional recommendations are approved orders must be written. The DON or designee will review nutritional recommendations for compliance weekly. " The Registered Dietitian will review all nutritional recommendations for compliance at her monthly review. The Dietary Manager, Minimum Data Set Support Nurse, and nurse managers full time, part time, and as needed staff will be required to complete this education. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has	

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F 692	Continued From page 60 stated she didn ' t know why the Med Pass didn ' t get implemented in June, but she added there was some turnover in the facility including the Administrator, Director of Nursing, and the Dietary Manager, all in the last couple of months. When she saw Resident #35 again in July, she noticed the Med Pass 2.0 wasn ' t ordered and recommended it again. On 7/20/22 at 11:16 AM, an observation was made of wound care to Resident #35 ' s sacral wound. The wound was large and covered the entire sacral area and beyond. On 7/21/22 at 11:13 AM, the Director of Nursing was interviewed. He stated recommendations from the dietician should be put into place.	F 692	been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that nutritional recommendations have been completed using the F692 Quality Assurance Tool. Monitoring of 6 residents with nutritional recommendations will be completed weekly to assure compliance with nutritional recommendations. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	
F 756 SS=J	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		8/18/22

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F 756	Continued From page 61 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 62 Based on record review, consultant pharmacists, Nurse Practitioner and Medical Director interviews, the facility failed to complete an evaluation of Resident #46's medication regimen that identified the need to monitor insulin administration. Resident #46's initial medication regimen review did not identify the inadequate monitoring of insulin administration. Resident #46 received daily insulin without blood sugar testing and experienced critically low blood sugars identified through bloodwork. This was for 1 of 3 residents reviewed for pharmacy services. Also, the facility failed to retain the consultant pharmacist's findings, recommendations, and provider response in the resident's medical record or within the facility so the records were readily available for 6 of 13 residents whose medications were reviewed (Resident #24, #15, #4, #65, #168, and #218). And the facility failed to act on the Pharmacy Consultant recommendations to complete an abnormal involuntary movement (AIMS) assessment for 1 of 5 residents (Resident #22) reviewed for unnecessary medications. Immediate jeopardy began on 7/14/22 when consultant pharmacist #1 reviewed Resident #46's medications and failed to recognize there were no physician orders for blood sugar testing with the administration of insulin and was removed on 7/21/22 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity E (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The facility was also cited at a scope and severity	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #46 is deceased therefore no corrective action was required. Resident #168 is deceased therefore no corrective action was required. Resident #218 is deceased therefore no corrective action was required. On 08/14/2022, a corrective action was obtained for resident #4. The most recent pharmacy recommendation from July 2022 was reviewed with the provider and approved. New order from the July 2022 pharmacy recommendation was written in resident #4□s Electronic Medical Record. On 08/12/2022, a corrective action was obtained for resident #65. The most recent pharmacy recommendation from July 2022 was reviewed with the provider	

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F 756	Continued From page 63 of E for example #2 (Resident #24, #15, #4, #65, #168, and #218) and for example #3 (Resident #22). The findings included: Resident #46 was readmitted to the facility on 7/12/22 with diagnoses including Covid, left hip fracture and insulin-dependent diabetes mellitus. He was on insulin with regular blood sugar checks during previous admission. Resident #46 died in the facility on 7/17/22. A hospital discharge summary dated 7/12/22 included an order for long-acting basal insulin 20 units daily (long-acting means insulin enters bloodstream in 2-4 hours from administration time and can last up to 24 hours in the body) and blood sugar test strips to check blood sugars four times daily as directed. The hospital discharge summary dated 7/12/22 also included an order to draw a complete blood count, basic metabolic panel, and thyroid stimulating hormone on 7/13/22. A physician's order dated 7/12/22 was insulin degludec (long-acting insulin) 100 unit/milliliter-inject 20 units subcutaneously one time a day for diabetes mellitus. There were no orders for monitoring blood sugar levels. The initial pharmacy review dated 7/14/22, completed by consultant pharmacist #1 showed no medication issues with Resident #46's current insulin orders. The review did not acknowledge the insulin. Consultant pharmacist #1 was unable to be interviewed.	F 756	and approved. New order from the July 2022 pharmacy recommendation was written in resident #65□s EMR. On 08/01/2022, a corrective action was obtained for resident #15. The most recent pharmacy recommendation from July 2022 was reviewed with the provider and approved. New order from the July 2022 pharmacy recommendation was written in resident #15□s EMR. On 08/12/2022, a corrective action was obtained for resident #24. The most recent pharmacy recommendation from July 2022 was reviewed with the provider and approved. Assessment for AIM□s recommended from the July 2022 pharmacy recommendation was completed in resident #24□s EMR. On 08/12/2022, a corrective action was obtained for resident #22. The most recent pharmacy recommendation from July 2022 was reviewed with the provider and approved. New order from the July 2022 pharmacy recommendation was written in resident #22□s EMR. Additionally, on 07/20/2022, an assessment for AIM□s from a previous pharmacy recommendation was completed in resident #22□s EMR. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 07/20/2022, the Pharmacy Director completed an audit of 18 residents who	

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F 756	Continued From page 64 During an interview on 7/19/22 at 3:20 pm, consultant pharmacist #2 stated that consultant pharmacist #1 completed the initial medication reviews for the new admissions to the facility. She stated that they do not receive fingerstick blood sugar orders. They only receive medication orders and that is what they review and base their recommendations on. She stated that the facility was responsible for ordering and keeping up with fingerstick orders. When asked if blood sugars were something they would monitor during their pharmacy reviews, she stated no, she probably would not look at those. She stated the review was based on medication orders only. During an interview with the Nurse Practitioner on 7/19/22 at 3:35 pm, she stated that she was not aware that Resident #46 was not receiving any fingerstick blood checks. She stated he was newly admitted and she had not had a chance to evaluate him yet. She also relayed the importance of finger stick sugar checks in the presence of insulin and she would expect finger stick blood sugar results to be on the resident's medication administration record for review. She added that you should not administer insulin if you don't know what the current sugar level is and that insulin is adjusted based on the daily blood sugar results. The Administrator was notified of immediate jeopardy on 7/20/22 at 12:37pm. The facility provided a credible allegation of immediate jeopardy removal dated 7/21/2022. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as	F 756	were potentially affected by the noncompliance by completing a comprehensive review of all new admissions/readmissions for the month of July 2022. The audit consisted of a review of insulin dependent diabetics to ensure orders for diabetic monitoring are in place. The pharmacy consultant also reviewed current lab results. Recommendations based on this review were sent to the physician by the nurse supervisor on 7/20/2022. These recommendations may include: additional labs, order changes, or additional diabetic monitoring. There were no other residents impacted. On 08/12/2022, the Director of Nurses (DON) completed an audit to review 100% of the pharmacy recommendations from July 2022 □ August 2022. This audit consisted of reviewing the pharmacy recommendations to ensure the provider has reviewed them and that orders were written into the (EMR) if approved by the provider. All recommendations that required orders will have orders written in the EMR no later than 08/18/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: As of 07/20/2022, the nurse consultant educated the pharmacy director on the need for all pharmacist consultants to review new admissions and readmissions to conduct comprehensive review that includes reviewing discharge summaries	

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F 756	Continued From page 65 a result of the noncompliance. Resident # 46 was deceased on 07/17/2022 and is no longer a resident of the facility. On 07/20/2022, the Pharmacy Director completed an audit of 18 residents who were potentially affected by the noncompliance by completing a comprehensive review of all new admissions/readmissions for the month of July 2022. The audit consisted of a review of insulin dependent diabetics to ensure orders for diabetic monitoring are in place. The pharmacy consultant also reviewed current lab results. Recommendations based on this review were sent to the physician by the nurse supervisor on 7/20/2022. These recommendations may include: additional labs, order changes, or additional diabetic monitoring. There were no other residents impacted. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. As of 07/20/2022, the nurse consultant educated the pharmacy director on the need for all pharmacist consultants to review new admissions and readmissions to conduct comprehensive review that includes reviewing discharge summaries and comparing pre-hospital admission diabetic monitoring with readmission orders for monitoring and blood work orders and ensuring that the facility is providing comprehensive services for those residents with diabetic needs. In cases of irregularities identified, the consultant pharmacist will notify facility clinical leadership for immediate follow-up to the medical provider.	F 756	and comparing pre-hospital admission diabetic monitoring with readmission orders for monitoring and blood work orders and ensuring that the facility is providing comprehensive services for those residents with diabetic needs. In cases of irregularities identified, the consultant pharmacist will notify facility clinical leadership for immediate follow-up to the medical provider. On 07/20/2022 all current pharmacy consultants who service the facility were educated on the need for all pharmacist consultants to review new admissions and readmissions to conduct comprehensive review that includes reviewing discharge summaries and comparing pre-hospital admission diabetic monitoring with readmission orders for monitoring and blood work orders and ensuring that the facility is providing comprehensive services for those residents with diabetic needs. In cases of irregularities identified, the consultant pharmacist will notify facility clinical leadership for immediate follow-up to the medical provider. On 07/29/2022, the Pharmacy director initiated monitoring of the pharmacy consultant by a different pharmacy consultant who didn□t complete the review to ensure there is a comprehensive review that includes reviewing discharge summaries and comparing pre-hospital admission diabetic monitoring with readmission orders for monitoring and blood work orders and ensuring that the facility is providing	

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F 756	Continued From page 66 Pharmacy consultants will review all discharge summaries for new admissions and readmissions. In the event the pharmacy review identifies any insulin dependent diabetics, the consultant must review all orders to ensure orders for diabetic monitoring are in place. Additionally, the pharmacist consultant will review current labs and make recommendations to the physician if order changes, additional labs or additional diabetic monitoring is required. This will be completed at the time of the initial review to ensure residents with diabetes are receiving a comprehensive review with the necessary care and services, monitoring for their diabetes. On 7/20/22, The Regional Director of Operations had a conversation with the pharmacy director detailing the process for ongoing monitoring for those residents with diabetic needs, specifically closer monitoring of chart information for new admissions and readmissions, to include reviewing the facilities practices for providing care and services. Previous pharmacy audits did not include review of blood work or orders for insulin dependent diabetics. The Pharmacy Director will in-service all consultant staff that are assigned reviews for the facility on 7/20/2022. The Pharmacy Director will provide the completed in service packet the facility leadership to ensure the training has been completed and for review. The pharmacy director will ensure that any consultant pharmacists who does not complete the in-service training will not be allowed to review charts for the facility until the training is completed. This in-service was incorporated into	F 756	comprehensive services for those residents with diabetic needs. In cases of irregularities identified, the consultant pharmacist will notify facility clinical leadership for immediate follow-up to the medical provider. The pharmacy director will ensure that any new consultant pharmacists who does not complete the in-service training will not be allowed to review charts for the facility until the training is completed. This in-service was incorporated into the new pharmacy employee orientation for the above identified staff. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. On 08/12/2022, the Quality Assurance Clinical Nurse Consultant (QANC) educated the DON on the following topics using the Procedures for Handling the initial pharmacy review reports as well as the regular monthly pharmacy review reports. This education also included that once the Note to Attending Physician Prescriber is completed with the providers response; the DON will ensure a copy is scanned into the resident□s record and then the DON will file a copy in the binder titled pharmacy initial or monthly reviews. The DON will educate any nurse managers or nurse support staff which includes the Staff Development Coordinator (SDC), Minimum Data Set Nurse (MDS), Unit Support Nurse, and	

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F 756	Continued From page 67 the new pharmacy employee orientation for the above identified staff including the agency staff orientation. IJ Removal 7/21/2022 The credible allegation of immediate jeopardy removal was verified on 7/21/22 as evidenced by onsite validation through record review, and staff interviews. The facility nurse consultant met with the consulting pharmacist on 7/20/22 to complete an audit of current diabetic residents. They also met to discuss the need for reviewing discharge summaries for any monitoring orders for new and readmissions. The pharmacist will also review lab work and make recommendations depending on results. The facility immediate jeopardy removal was validated to be completed as of 7/21/22. 2-a) Resident #168 was admitted to the facility on 12/31/19 with re-entry on 10/23/21. His cumulative diagnoses included diabetes, hypertension, chronic obstructive pulmonary disease, Alzheimer ' s disease, dementia with behavioral disturbance, major depressive disorder and anxiety disorder. The resident ' s electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part: --On 7/6/21, an MRR conducted by the pharmacist included recommendations which read: "repeat." --On 8/10/21, an MRR conducted by the pharmacist included recommendations which read: "AIMS (Abnormal Involuntary Movement	F 756	Registered Nurse (RN) Supervisor, who assists with handling the initial pharmacy review reports as well as the regular monthly pharmacy review reports. On 08/18/2022, the Pharmacy Consultant was contacted to add other facility team members to receive the pharmacy review reports including the MDS Nurse and the SDC Nurse. The team will discuss and observe completion of the pharmacy reviews in their clinical meeting to ensure compliance. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that pharmacy review reports have been completed using the F756 Pharmacy Review Quality Assurance Tool. Monitoring of 6 residents with pharmacy reviews completed to	

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F 756	Continued From page 68 Scale), GDR (gradual dose reduction)." --On 9/7/21, an MRR conducted by the pharmacist included recommendations which read: "f/u (follow-up), AIMS." --On 10/12/21, an MRR conducted by the pharmacist included recommendations which read: "AIMS, documentation." No additional information was provided related to the consultant pharmacist ' s recommendations. Resident #168 ' s ' s EMR revealed a consultant pharmacist conducted an initial MRR on 10/25/21. The pharmacist ' s note from the MRR read: "Initial pharmacist medication regimen review completed. Recommendations made, see report." No additional information was provided related to the consultant pharmacist ' s recommendations. The resident ' s EMR included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part: --On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "AIMS, documentation." --On 2/15/22, an MRR conducted by the pharmacist included recommendations which read: "Repeat, AIMS." --On 3/18/22, an MRR conducted by the pharmacist included recommendations which read: "documentation." --On 4/20/22, an MRR conducted by the pharmacist included recommendations which read: "clinical doc (documentation)." --On 5/17/22, an MRR conducted by the pharmacist included recommendations which read: "repeat." No additional information was provided related to the consultant pharmacist ' s recommendations.	F 756	assure compliance with procedure for handling pharmacy review reports. Quality assurance audits will be completed by the Consultant pharmacist to ensure that a comprehensive pharmacy review was completed. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	

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An initial MRR was completed by a consultant pharmacist for Resident #168 on 6/9/22. The pharmacist note read, "Initial pharmacist medication regimen review completed. Recommendations made, see report." No additional information was provided related to the consultant pharmacist ' s recommendations.

On 6/14/22, a monthly MRR was conducted by the consultant pharmacist. The pharmacist recommendations read: "documentation." No additional information was provided related to the consultant pharmacist ' s recommendations.

Further review of Resident #168 ' s EMR revealed there were no Pharmacy Consultation Reports included in the resident ' s medical record to provide details from the MRR recommendations dated 7/6/21, 8/10/21, 9/7/21, 10/12/21, 10/25/21, 1/18/22, 2/15/22, 3/18/22, 4/20/22, 5/17/22, 6/9/22, or 6/14/22. Additionally, there was no documentation in Resident #168 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

2-b) Resident #218 was admitted to the facility on 1/22/20. Her cumulative diagnoses included Alzheimer ' s disease, osteoporosis, and depression.

The resident ' s electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part:
--On 8/9/21, an MRR conducted by the pharmacist included recommendations which read: "GDR (gradual dose reduction."

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--On 9/7/21, an MRR conducted by the pharmacist included recommendations which read: "f/u (follow-up)."
--On 10/11/21, an MRR conducted by the pharmacist included recommendations which read: "APAP (acetaminophen."
--On 2/15/22, an MRR conducted by the pharmacist included recommendations which read: "GDR."
--On 4/20/22, an MRR conducted by the pharmacist included recommendations which read: "clinical doc (documentation)."
--On 5/17/22, an MRR conducted by the pharmacist included recommendations which read: "prn (as needed)."
No additional information was provided related to the consultant pharmacist ' s recommendations.

Resident #218 ' s most recent Minimum Data Set (MDS) was a significant change assessment dated 5/18/22. The MDS assessment revealed she had severely impaired cognitive skills for daily decision making. The MDS reported the resident ' s medications included an antidepressant on 1 out of 7 days, an antibiotic on 7 out of 7 days and an opioid medication on 7 out of 7 days during the 7-day look back period.

Further review of Resident #218 ' s EMR revealed there were no Pharmacy Consultation Reports included in the resident ' s medical record to provide details from the MRR recommendations dated 8/9/21, 9/7/21, 10/11/21, 2/15/22, 4/20/22, or 5/17/22. Additionally, there was no documentation in Resident #218 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

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2-c) Resident #4 was admitted to the facility on 12/5/18. Her cumulative diagnoses included diabetes, renal insufficiency, and an adjustment disorder with mixed anxiety and depressed mood.

The resident ' s electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part:
--On 7/7/21, an MRR conducted by the pharmacist included recommendations which read: "repeat, documentation."
--On 8/10/21, an MRR conducted by the pharmacist included recommendations which read: "documentation."
--On 12/8/21, an MRR conducted by the pharmacist included recommendations which read: "lab."
--On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "lab."
--On 2/16/22, an MRR conducted by the pharmacist included recommendations which read: "GDR, repeat."
No additional information was provided related to the consultant pharmacist ' s recommendations.

Resident #4 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/18/22. The MDS assessment revealed she had cognitively intact skills for daily decision making. The MDS reported the resident ' s medications included insulin injection and antidepressant medication on 7 out of 7 days during the look back period.

On 7/17/22, a monthly MRR conducted by the pharmacist included recommendations which read: "labs." No additional information was

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provided related to the consultant pharmacist ' s recommendations.

Further review of Resident #4 ' s EMR revealed there were no Pharmacy Consultation Reports included in the resident ' s medical record to provide details from the MRR recommendations dated 7/7/21, 8/10/21, 12/8/21, 1/18/22, 2/16/22 or 7/17/22. Additionally, there was no documentation in Resident #4 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

2-d) Resident #65 was admitted to the facility on 7/3/18. Her cumulative diagnoses included anemia, hypertension, renal insufficiency, chronic obstructive pulmonary disease (COPD), anxiety disorder and depression.

The resident ' s electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part:
--On 8/10/21, an MRR conducted by the pharmacist included recommendations which read: "prn (as needed), lab."
--On 9/7/21, an MRR conducted by the pharmacist included recommendations which read: "f/u (follow-up)."
--On 10/11/21, an MRR conducted by the pharmacist included recommendations which read: "repeat."
--On 12/8/21, an MRR conducted by the pharmacist included recommendations which read: "lab, documentation."
--On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "repeat."

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--On 2/16/22, an MRR conducted by the pharmacist included recommendations which read: "repeat."
--On 3/19/22, an MRR conducted by the pharmacist included recommendations which read: "documentation."
--On 4/20/22, an MRR conducted by the pharmacist included recommendations which read: "clinical doc (documentation)."
No additional information was provided related to the consultant pharmacist ' s recommendations.

Resident #65 ' s most recent Minimum Data Set (MDS) was an annual assessment dated 7/8/22. The MDS assessment revealed she had moderately impaired cognitive skills for daily decision making. The MDS reported the resident ' s medications included an antidepressant, antibiotic, and opioid medication on 7 out of 7 days and a diuretic on 1 out of 7 days during the 7-day look back period.

On 7/17/22, a monthly MRR conducted by the consultant pharmacist included recommendations which read: "Probiotic, inhalers, documentation." No additional information was provided related to the consultant pharmacist ' s recommendations.

Further review of Resident #65 ' s EMR revealed there were no Pharmacy Consultation Reports included in the resident ' s medical record to provide details from the MRR recommendations dated 8/10/21, 9/7/21, 10/11/21, 12/8/21, 1/18/22, 2/16/22, 3/19/22, or 4/20/22. Additionally, there was no documentation in Resident #65 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

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2-e) Resident #15 was admitted to the facility on 4/1/22. His cumulative diagnoses included a seizure disorder, hypertension, heart failure, and respiratory failure.

Resident #15 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/13/22. The MDS assessment revealed he had moderately impaired cognitive skills for daily decision making. The MDS reported the resident ' s medications included an antidepressant, anticoagulant, and diuretic medication on 7 out of 7 days during the look back period.

The resident ' s electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part:
--On 5/16/22, an MRR conducted by the pharmacist included recommendations which read: "documentation."
--On 6/13/22, an MRR conducted by the pharmacist included recommendations which read: "lab, repeat."
--On 7/17/22, an MRR conducted by the pharmacist included recommendations which read: "repeat."
No additional information was provided related to the consultant pharmacist ' s recommendations.

Further review of Resident #15 ' s EMR revealed there were no Pharmacy Consultation Reports included in the resident ' s medical record to provide details from the MRR recommendations dated 5/16/22, 6/13/22 or 7/17/22. Additionally, there was no documentation in Resident #15 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were

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reviewed or a response was received from the provider.

2-f) Resident #24 was admitted to the facility on 5/21/22. His cumulative diagnoses included a history of multiple fractures, hypertension and unspecified dementia with behavioral disturbance.

The resident ' s electronic medical record (EMR) revealed a consultant pharmacist conducted an initial pharmacist medication regimen review (MRR) on 5/23/22. The pharmacist ' s note from the MRR included documentation which read: "Initial pharmacist medication regimen review completed. Recommendations made, see report."

Resident #24 ' s admission Minimum Data Set (MDS) dated 5/27/22 revealed he had moderately impaired cognitive skills for daily decision making. The resident ' s MDS assessment indicated his medications included an antipsychotic medication on 4 out of 7 days and a diuretic on 5 out of 7 days during the look back period.

The resident ' s EMR included the following monthly MRRs completed by the consultant pharmacist:
--On 6/13/22, an MRR conducted by the pharmacist included recommendations which read: "documentation, AIMS (Abnormal Involuntary Movement Scale)."
--On 7/17/22, an MRR conducted by the pharmacist included recommendations which read: "repeat, AIMS."

Further review of Resident #24 ' s EMR revealed there were no Pharmacy Consultation Reports included in the resident ' s medical record to

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provide details from the MRR recommendations dated 5/23/22, 6/13/22, or 7/17/22. Additionally, there was no documentation in Resident #24 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

An interview was conducted on 7/19/22 at 10:27 AM with the corporate floating Director of Nursing (DON) who served as the facility ' s Interim DON from 2/16/22 - 5/23/22. During the interview, the float DON was asked if the consultant pharmacist recommendations, consultation reports and provider response for Resident #168, Resident #218, Resident #4, Resident #65, Resident #15, and Resident #24 were available for review. During a follow-up interview conducted with the floating DON, she reported only one "Note to Attending Physician/Prescriber" originating from a pharmacist MRR could be located. She stated no additional pharmacy recommendations were found in the residents ' medical records or elsewhere in the facility.

An interview was conducted on 7/20/22 at 9:56 AM with the facility ' s consultant pharmacist. During the interview, the pharmacist was asked to describe the process used at the facility for sharing the MRR monthly recommendations with the residents' provider. The pharmacist reported she would write a progress note in each resident ' s EMR to indicate whether or not she had pharmacy recommendations. She reported some recommendations were intended for nursing staff and these would go into a "Nursing Note." Other pharmacy recommendations were intended for the provider. The pharmacist reported she would typically send all of her notes and

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recommendations via email to the DON and Regional Nurse Consultant and would flag "important or urgent" issues. The pharmacist stated it was up to the DON to print and distribute/delegate the Nursing Notes. The pharmacist reported she has asked the facility to upload the pharmacy recommendations with responses from the provider into each resident ' s EMR. When asked, the consultant pharmacist reiterated she would expect the pharmacy recommendations with the provider ' s response to be scanned into each resident ' s electronic medical record.

A telephone interview was conducted on 7/20/22 at 2:00 PM with the facility ' s Nurse Practitioner (NP). During the interview, the NP described the process employed for receiving the pharmacist's recommendations, reviewing, and responding to them. She reported she received the pharmacist ' s recommendations when the DON put them in her book. The NP stated she typically reviewed the recommendations, noted what she wanted to be done, and gave them back to the DON. The NP reported the DON would enter any order changes into the resident ' s EMR. After that, it was the NP ' s understanding that the DON would give these reports to medical records to be scanned in to the resident's EMR.

An interview was conducted on 7/20/22 at 3:55 PM with the facility ' s Interim DON. During the interview, the DON reported he was aware of the concern regarding the pharmacist ' s recommendations and provider responses not being available for review. The DON indicated he would expect the regulations to be followed.

3. Resident #22 was admitted to the facility on

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1/5/2018 with diagnoses that included a cerebral infarction, Parkinson's disease, depression, dementia, and anxiety.

A review of the quarterly Minimum Data Set (MDS) dated 5/25/2022 revealed Resident #22 had severe cognitive impairment with inattention, disorganized thinking and verbal behaviors directed towards others. The assessment documented she received an antipsychotic 6 days and an antidepressant 7 days of the 7-day lookback period. The antipsychotics were on a routine basis only.

A review of the electronic medical record for Resident #22 revealed an initial admission AIMS was completed on the date of 9/1/2021.

A review of the Pharmacy medication regimen review for 12/6/2021 written by the Pharmacy Consultant #1 for Resident #22 requested an AIMS due to the Resident receiving Olanzapine, an antipsychotic medication.

A review of the Pharmacy medication regimen review for 1/17/2022 written by the Pharmacy Consultant #1 for Resident #22 repeated the request for an AIMS for the Resident.

A review of the Pharmacy medication regimen review for 2/15/2022 written by the Pharmacy Consultant #1 for Resident #22 repeated the request for an AIMS for the Resident.

A review of the electronic medical record for Resident #22 revealed a second AIMS assessment was completed on 3/9/2022.

A review of the Pharmacy medication regimen

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review for 6/13/2022 written by the Pharmacy Consultant #1 for Resident #22 requested an AIMS due to the Resident continuing to receive an antipsychotic medication.

A review of the Pharmacy medication regimen review for 7/16/2022 written by the Pharmacy Consultant #1 for Resident #22 repeated the request for an AIMS for the Resident due to her continuing to receive an antipsychotic medication.

On 7/20/2022 at 2:04 p.m. an interview was conducted with the Unit Manager, and she revealed she received emails from the pharmacy consultant with the nursing monthly medication regimen review recommendation and request that also stated when to conduct an AIMS assessment. She revealed she was not sure if the AIMS assessment were due every three months or six months and would need to ask her Director of Nursing because she completed the AIMS assessments when she received instructions to do so in the emails from the Pharmacy consultant and Minimum Data Set (MDS) consultant. She reviewed the chart for Resident #22 and revealed she was able to see where the Pharmacy consultant documented the request for an AIMS on 12/6/2021, 1/17/2022, and 2/15/2022 and then again on 6/13/2022 and 7/16/2022. She stated she had been out of work due to an illness in June, 2022 and was not sure who the request had been emailed to but the AIMS was not completed in June 2022 as requested. She revealed in December 2021 and January 2022 a different Director of Nursing (DON) had been employed and the emails were going directly to the DON. The nursing recommendations requested from the Pharmacy Consultant had begun to be sent to the Unit

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F 756	Continued From page 80 managers in addition to the DON to improve on the follow up. She added the second AIMS was not completed until March of 2022. An interview was conducted with the interim DON on 7/20/2022 and he revealed the facility protocol for an AIMS assessment was to be conducted upon admission and every 6 months. He stated the facility protocol to follow up on Pharmacy consultant recommendations was for the request to be expedited as quickly as possible based on the situation and medication. He added a request for an assessment like an AIMS, the goal was for a turn around as quickly as possible, and this should be conducted before the pharmacist returns the following month.	F 756		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 25 medication opportunities, resulting in a medication error rate of 12% for 1 of 6 residents (Resident #24) observed during medication pass. The findings included: 1) Resident #24 was admitted to the facility on 5/21/22. His cumulative diagnoses included a	F 759	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates	8/18/22

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F 759	Continued From page 81 history of multiple fractures and hypertension. On 7/17/22 at 10:04 AM, Medication Aide (Med Aide) #1 was observed as she checked Resident #24 ' s vital signs. His vital signs included a blood pressure of 115/65 and pulse of 69 beats per minute (bpm). After the resident ' s vital signs were taken, the med aide was observed as she prepared 10 oral medications for administration to Resident #24. The medications pulled for administration included one tablet of 100 milligrams (mg) metoprolol succinate (an extended release formulation of an anti-hypertensive medication). The med aide was observed as she crushed the metoprolol succinate tablet along with 8 other oral medications. The med aide stirred the crushed medications into a pudding as she prepared to administer them to Resident #24. On 7/17/22 at 10:32 AM, Med Aide #1 was asked to stop before going into Resident #24 ' s room with the medications prepared for administration. When she was informed the metoprolol succinate tablet could not be crushed prior to administration, Nurse #1 came to the med cart to assist the med aide. At that time, Nurse #1 told the med aide to re-pull the medications for Resident #24 and instructed her not to crush the metoprolol succinate tablet. The med aide was again observed as she prepared the resident ' s medications for administration. She placed the metoprolol succinate tablet (whole) into a med cup with pudding. Med Aide #1 administered the oral medications to Resident #24 on 7/17/22 at 10:43 AM. According to Lexi-Comp, a comprehensive electronic medication database, metoprolol	F 759	indicated. F759 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/11/2022 the Director of Nurses assessed resident #24, there were no findings of harm to resident #24. Additionally, the MD was notified of medication errors for resident #24 on 07/19/2022 and there were no new orders. Medication aide #1 has not worked since the facility was notified of the alleged deficient practice. 2. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 07/20/2022 and 07/21/2022, the Pharmacy Consultant completed random medication administration observations with licensed nurses and medication aides to validate staff competency with medication administration. On 08/11/2022 the DON began auditing 100% of resident medication administration records of residents with active orders for metoprolol with parameters and hydrochlorothiazide with parameters to identify any administration of medications outside of the parameters or residents who receive their medications crushed and have orders for enteric coated aspirin which should not be	

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F 759	Continued From page 82 succinate tablets should not be crushed or chewed. A review of Resident #24 ' s medication orders conducted on 7/18/22 revealed an order was received on 6/7/22 for 100 mg metoprolol succinate to be given as one tablet by mouth one time a day for hypertension. The order also included instructions to hold this medication for a systolic blood pressure less than 120 and a heart rate less than 60 bpm. Systolic blood pressure is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading. An interview was conducted with Med Aide #1 on 7/18/22 at 1:40 PM. At that time, the Med Aide was shown the orders on Resident #24's July 2022 Medication Administration Record (MAR) and vital signs taken at the time of the medication administration observation on 7/17/22. When she reviewed the MAR, vital sign results, and parameters of the order for Resident #24 ' s metoprolol succinate, Med Aide #1 stated she should not have administered this medication to him. An interview was conducted on 7/19/22 at 10:47 AM with the facility ' s Interim Director of Nursing (DON). During the interview, the observations made during the medication administration pass were discussed. When asked about crushing a metoprolol succinate tablet, the DON stated, "If those are listed as one medication the manufacturer and doctor specifies should not be crushed, (nursing staff) should follow those guidelines." While discussing the vital sign parameters and instructions provided in the medication order for metoprolol succinate, the	F 759	crushed. The results of the audit were shared with the physician. There were no new orders received. Corrections were made to add supplemental information in the order to aid in monitoring of the parameters. Medication error reports was completed for resident #24. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/25/2022 the SDC Nurse began educating all full time, part time, and prn licensed nurses Registered Nurses (RN) and Licensed Practical Nurses (LPN), and medication aides including agency staff on the following topics: " Prevention of medication errors " Following Medication orders for parameters " Following the 6 rights of medication administration Beginning 08/11/2022, the SDC will validate competency of following parameters and crushing medications. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022.	

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F 759	Continued From page 83 DON stated he would expect nursing staff, "To follow the guideline as it (the order) specifies." When asked if the medication should have been administered to Resident #24 given the results of his vital signs taken, the DON stated, "Not according to the way the order was written." When asked, the DON stated he would expect nursing staff, "To follow the guideline as it (the order) specifies." When asked if these meds should have been administered to Resident #24 given the results of his vital signs taken, the DON stated, "Not according to the way the order was written." 2) Resident #24 was admitted to the facility on 5/21/22. His cumulative diagnoses included a history of multiple fractures and hypertension. On 7/17/22 at 10:04 AM, Med Aide #1 was observed as she checked Resident #24 ' s vital signs. His vital signs included a blood pressure of 115/65 and pulse of 69 beats per minute (bpm). After the resident ' s vital signs were taken, the med aide was observed as she prepared 10 oral medications for administration to Resident #24. The medications pulled for administration included one tablet of 25 milligrams (mg) hydrochlorothiazide (a diuretic). Med Aide #1 administered the hydrochlorothiazide (along with the other oral medications) to Resident #24 on 7/17/22 at 10:43 AM. A review of Resident #24 ' s medication orders conducted on 7/18/22 revealed an order was received on 6/7/22 for 25 mg hydrochlorothiazide to be given as one tablet by mouth one time a day for hypertension. The order also included	F 759	1. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F759 Medication Observation Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that we are free of medication error rates less than 5 percent. This will include monitoring medication pass of 4 employees RN□s, LPN□s, or medication aides on various shifts, halls, and days to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	

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instructions to hold this medication for a systolic blood pressure less than 120 and a heart rate less than 60 bpm. Systolic blood pressure is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading.

An interview was conducted with Med Aide #1 on 7/18/22 at 1:40 PM. At that time, the Med Aide was shown the orders on Resident #24's July 2022 Medication Administration Record (MAR) and vital signs taken at the time of the medication administration observation on 7/17/22. When she reviewed the MAR, vital sign results, and parameters of the order for Resident #24 ' s hydrochlorothiazide, Med Aide #1 stated she should not have administered this medication to him.

An interview was conducted on 7/19/22 at 10:47 AM with the facility ' s Interim Director of Nursing (DON). During the interview, the observations made during the medication administration pass were discussed. While discussing the vital sign parameters and instructions provided in the medication order for hydrochlorothiazide, the DON stated he would expect nursing staff, "To follow the guideline as it (the order) specifies." When asked if the medication should have been administered to Resident #24 given the results of his vital signs taken, the DON stated, "Not according to the way the order was written."

3) Resident #24 was admitted to the facility on 5/21/22. His cumulative diagnoses included a history of multiple fractures and hypertension.

On 7/17/22 at 10:11 AM, Med Aide #1 was observed as she prepared 10 oral medications for

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F 759	Continued From page 85	F 759		

administration to Resident #24. The medications pulled for administration included two (2) tablets of 81 milligrams (mg) Enteric Coated (EC) aspirin. The med aide was observed as she crushed the EC aspirin tablets with 7 other oral medications. The med aide stirred the crushed medications into a pudding as she prepared to administer them to Resident #24.

On 7/17/22 at 10:32 AM, Med Aide #1 was asked to stop before going into Resident #24 ' s room with the medications prepared for administration. When the med aide was informed the EC aspirin tablets could not be crushed prior to administration, Nurse #1 came to the med cart to assist the med aide. At that time, Nurse #1 told the med aide to re-pull the medications for Resident #24 and she obtained a stock bottle of 81 mg chewable aspirin to be crushed in place of the EC aspirin for the resident. The med aide then crushed two chewable aspirin tablets with 6 other oral medications, stirred the crushed medications into pudding, and administered the medications to Resident #24 on 7/17/22 at 10:43 AM.

According to Lexi-Comp, a comprehensive electronic medication database, enteric-coated aspirin tablets should not be crushed or chewed; these preparations should be swallowed whole.

A review of Resident #24 ' s medication orders conducted on 7/18/22 revealed an active order was received on 6/22/22 for one - 81 mg EC aspirin to be given as one tablet by mouth every 12 hours for 6 weeks with a start date of 6/22/22 and an end date of 8/3/22 (scheduled for 8:00 AM and 8:00 PM daily). Another active medication order was received on 6/22/22 for one - 81 mg

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F 759	Continued From page 86 EC aspirin tablet to be given by mouth one time a day with a start date of 7/3/22 (scheduled for 9:00 AM daily). An interview was conducted on 7/19/22 at 10:47 AM with the facility ' s Interim Director of Nursing (DON). During the interview, the observations made during the medication administration pass were discussed. When asked about crushing EC aspirin tablets, the DON stated, "If those are listed as one medication the manufacturer and doctor specifies should not be crushed, (nursing staff) should follow those guidelines."	F 759		
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 observations, staff, consultant pharmacist, and Nurse Practitioner (NP) interviews and record review, the facility failed to hold the administration of antihypertensive medications when a resident ' s blood pressure / heart rate were outside of the parameters indicated by his physician orders. This occurred for 1 of 6 residents (Resident #24) reviewed for medications administered during the med pass observations. The findings included: Resident #24 was admitted to the facility on 5/21/22. His cumulative diagnoses included a history of multiple fractures and hypertension.	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 1. Corrective action for resident(s)	8/18/22

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F 760	Continued From page 87 Resident #24 ' s admission orders dated 5/21/22 included the following, in part: --25 milligrams (mg) hydrochlorothiazide (a diuretic) to be given as one tablet by mouth once daily for hypertension; --100 mg metoprolol succinate (an extended release formulation of an anti-hypertensive medication) to be given as one tablet by mouth once daily for hypertension. Resident #24 ' s admission Minimum Data Set (MDS) dated 5/27/22 revealed he had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance for bed mobility, dressing, eating, and personal hygiene. He was totally dependent on staff for transfers and toileting. Resident #24 ' s MDS reported he had a history of fall(s) 2 to 6 months prior to admission and a fracture related to a fall within 6 months prior to his admission to the facility. The resident ' s MDS assessment also indicated he sustained two or more falls without injury since his admission to the facility. Resident #24 ' s care plan included an area of focus which read, "I have had actual falls with risk for further (Date Initiated: 5/26/22; Revision on 6/3/22)." The planned interventions included, in part: Med review (Date Initiated: 5/29/22; Revision on: 6/28/22); and Medication Adjustment (Date Initiated: 6/6/22). On 6/7/22, a physician ' s order was received to add blood pressure and heart rate parameters for the administration of Resident #24 ' s antihypertensive medications. The start date for the new order was 6/8/22. The order included: --25 mg hydrochlorothiazide to be given as one tablet by mouth once daily for hypertension; Hold	F 760	affected by the alleged deficient practice: On 08/11/2022 the Director of Nurses (DON) assessed resident #24, there were no findings of harm to resident #24. Additionally, the MD was notified of medication errors for resident #24 on 07/19/2022 and there were no new orders. Medication aide #1 has not worked since the facility was notified of the alleged deficient practice. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. On 07/20/2022 and 07/21/2022, the Pharmacy Consultant completed random medication administration observations with licensed nurses and medication aides to validate staff competency with medication administration. On 08/11/2022 the DON began auditing 100% of resident medication administration records of residents with active orders for metoprolol with parameters and hydrochlorothiazide with parameters to identify any administration of medications outside of the parameters or residents who receive their medications crushed and have orders for enteric coated aspirin which should not be crushed. The results of the audit were shared with the physician. There were no new orders received. Corrections were made to add supplemental information in	

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F 760	Continued From page 88 for Systolic Blood Pressure (SBP is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading) less than 120 and Heart Rate (HR) less than 60. Hydrochlorothiazide was scheduled to be administered to the resident at 9:00 AM each day. --100 mg metoprolol succinate to be given as one tablet by mouth once daily for hypertension. Hold for SBP less than 120 and HR less than 60. Metoprolol succinate was also scheduled to be administered to the resident at 9:00 AM each day. Resident #24 ' s June 2022 Medication Administration Record (MAR) was reviewed. The MAR documented the resident ' s metoprolol succinate and hydrochlorothiazide were given on each of the following dates when the SBP / HR were outside of a parameter indicated by the physician ' s orders: --On 6/16/22, the resident ' s SBP was 118 and HR was 65; both metoprolol succinate and hydrochlorothiazide were documented as having been administered to the resident by Nurse #2. --On 6/20/22, the resident ' s SBP was 118 and HR was 88; both metoprolol succinate and hydrochlorothiazide were documented as having been administered to the resident by Nurse #3. --On 6/21/22, the resident ' s SBP was 104 and HR was 80; both metoprolol succinate and hydrochlorothiazide were documented as having been administered to the resident by Nurse #4. --On 6/29/22, the resident ' s SBP was 112 and HR was 62; both metoprolol succinate and hydrochlorothiazide were documented as having been administered to the resident by Nurse #5. A telephone interview was conducted on 7/20/22 at 2:20 PM with Nurse #2. Nurse #2 was	F 760	the order to aid in monitoring of the parameters. Medication error report was completed for resident #24. " Preventing medication errors " Validating competency following medication parameters " 6 rights of medication administration " Following medication safety practices 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 07/25/2022 the SDC Nurse began educating all full time, part time, and prn licensed nurses Registered Nurses (RN) and Licensed Practical Nurses (LPN), and medication aides including agency staff on the following topics: " Prevention of medication errors " Following Medication orders for parameters " Following the 6 rights of medication administration Beginning 08/11/2022, the SDC will validate competency for the education on preventing medication errors to all Full Time, Part Time, and (PRN) Nurses; RNs, LPNs, and Medication Aides. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the	

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F 760	Continued From page 89 identified as an Agency (temporary) nurse who documented on the MAR that Resident #24 ' s metoprolol succinate and hydrochlorothiazide were administered on 6/16/22 when his SBP / HR parameters indicated the medications should have been held. During the interview, the resident ' s vital signs and physician ' s order were discussed. The nurse reported she typically would have held the medications under these circumstances and coded the MAR to indicate these meds were not given. Nurse #2 stated that sometimes a resident ' s blood pressure was taken after the medications were administered. Upon further inquiry, the nurse would not elaborate on this comment. A telephone interview was conducted on 7/20/22 at 2:35 PM with Nurse #3. Nurse #3 was identified as an Agency nurse who documented on the MAR that Resident #24 ' s metoprolol succinate and hydrochlorothiazide were administered on 6/20/22 when his SBP / HR parameters indicated the medications should have been held. When asked, the nurse reported if a medication was not given, he would check a box on the electronic MAR to indicate the med was not given "per parameters." He reported a check mark with his initials would indicate the medication(s) was administered. An interview was conducted on 7/20/22 at 2:49 PM with Nurse #4. Nurse #4 was identified as an Agency nurse who documented on Resident #24 ' s MAR that his metoprolol succinate and hydrochlorothiazide were administered on 6/21/22 when his SBP / HR parameters indicated the medications should have been held. During the interview, Resident #24 ' s June MAR was reviewed with the nurse. The MAR included the	F 760	facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F760 Medication Observation Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that we are free of significant medication errors. This will include monitoring medication pass of 4 employees RN□s, LPN□s, or medication aides on various shifts, halls, and days to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. ate of Compliance: 08/18/2022	

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resident ' s SBP / HR and a check mark with the nurse ' s initials to indicate the medications were given on this date. When shown the information and documentation on Resident #24 ' s MAR, the nurse stated she did not know for sure whether she made an error in charting or an error in administering the medications to the resident when she should not have.

Nurse #5 could not be reached for a telephone interview. Nurse #5 was identified as an Agency nurse who documented on Resident #24 ' s MAR that his metoprolol succinate and hydrochlorothiazide were administered on 6/29/22 when his SBP / HR parameters indicated the medications should have been held.

An observation was conducted on 7/17/22 at 10:04 AM as Med Aide #1 checked Resident #24 ' s vital signs prior to administering his medications. The resident ' s vital signs included a blood pressure of 115/65 and heart rate of 69. Med Aide #1 was observed as she administered 100 mg metoprolol succinate and 25 mg hydrochlorothiazide to Resident #24 on 7/17/22 at 10:43 AM.

An interview was conducted with Med Aide #1 on 7/18/22 at 1:40 PM. At that time, the Med Aide was shown the orders on Resident #24's MAR and the vital sign results obtained at the time of the medication administration observation on 7/17/22. Upon review of the MAR, vital sign results, and parameters of the order for Resident #24 ' s metoprolol succinate and hydrochlorothiazide, Med Aide #1 stated she should not have administered these medications to the resident.

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A telephone interview was conducted on 7/19/22 at 3:56 PM with the Nurse Practitioner (NP) who cared for Resident #24. During the interview, the NP stated, "If there are parameters there (on the order), they should be followed." The NP reported the reason parameters were added to the anti-hypertensive medication orders was because it was thought Resident #24 may be falling due to orthostatic hypotension. She added, "The parameters were implemented just to be on the safe side." When asked, the provider stated the orders given for metoprolol succinate and hydrochlorothiazide would have indicated that if only one or the other of the parameters was met, the medication needed to be held.

An interview was conducted on 7/20/22 at 10:19 AM with the facility ' s consultant pharmacist. During the interview, Resident #24 ' s orders for metoprolol succinate and hydrochlorothiazide were reviewed, along with the SBP and HR parameters given in the medication orders. The documented instances of 6/16/22, 6/20/22, 6/21/22 and 6/29/22 and the observation of these medications being administered on 7/17/22 when the resident ' s SBP / HR parameters indicated the medications should have been held were also discussed. When asked what her thoughts were regarding the metoprolol succinate and hydrochlorothiazide being given when Resident #24 ' s SBP was less than 120, the pharmacist stated, "They shouldn't have been given." Upon further inquiry, the consultant pharmacist stated, "It could be pretty significant with both of them (metoprolol succinate and hydrochlorothiazide)."

An interview was conducted on 7/19/22 at 10:47 AM with the facility ' s Interim Director of Nursing (DON). During the interview, the vital sign

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F 760	Continued From page 92 parameters and instructions provided in the medication orders for Resident #24 ' s hydrochlorothiazide and metoprolol succinate were discussed. The DON stated he would expect nursing staff, "To follow the guideline as it (the order) specifies." When asked if these medications should have been administered to Resident #24 given the results of his vital signs taken, the DON stated, "Not according to the way the order was written."	F 760		
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.	F 761		8/18/22

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F 761	Continued From page 93 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to: 1) Label medications with the minimum information required, including the name of the resident, on 2 of 2 medication carts observed (the 300 Hall Med Cart and the 100 Hall Med Cart); 2) Discard expired medications on 2 of 2 medication carts observed (the 300 Hall Med Cart and the 100 Hall Med Cart); and 3) Label medications with the date they were opened on 1 of 2 medication carts (the 100 Hall Med Cart) and in 1 of 1 medication storage rooms (the 100/200 Med Storage Room) observed to allow its shortened expiration date to be determined. The findings included: 1-a) An observation was conducted on 7/17/22 at 2:52 PM of the 300 Hall medication cart in the presence of Nurse #6. The observation revealed an opened Levemir FlexTouch insulin pen was stored on the med cart. There was no label on the insulin pen to indicate the resident's name, dispensed date, or date opened. Nurse #6 confirmed the insulin pen had been opened and had no identifying information on it. She stated, "It shouldn't be on there" and reported the pen needed to be discarded. 1-b) An observation was conducted on 7/17/22 at 2:52 PM of the 300 Hall medication cart in the presence of Nurse #6. The observation revealed an opened Insulin Lispro Kwikpen was stored on the medication cart. There was no label on the insulin pen to indicate the resident's name, dispensed date, or date opened. Nurse #6 confirmed the insulin pen had been opened and had no identifying information on it. She stated,	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #40, the Atrovent HFA inhaler was removed and discarded from the cart on 07/17/2022 by Nurse #7. Resident #370, the Nitroglycerin was removed and discarded on 07/17/2022 by Nurse #6. The identified expired over the counter medications were discarded on 07/17/2022 by the Nurse #7. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 07/22/2022, The Director of	

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F 761	Continued From page 94 "It shouldn't be on there" and reported the pen needed to be discarded. 1-c) An observation was conducted on 7/17/22 at 2:52 PM of the 300 Hall medication cart in the presence of Nurse #6. The observation revealed a medication vial containing 36 unidentified, white oval tablets was stored on the med cart. The vial was not labeled with any printed or hand-written information. Therefore, the vial of tablets did not provide any of the minimum required labeling information, including the name of the drug or the name of the resident the tablets were dispensed for. 1-d) An observation was conducted on 7/17/22 at 3:10 PM of the 100 Hall medication cart in the presence of Nurse #7. The observation revealed two metered dose inhalers (MDI) were stored in the same box (a manufacturer's box labeled for 17 micrograms (mcg) / actuation Atrovent HFA). Atrovent HFA is an inhaled medication used to treat chronic obstructive pulmonary disease (COPD). One of the inhalers stored in the box was an Atrovent HFA metered dose inhaler labeled as dispensed for Resident #40. The second MDI was an albuterol inhaler. Albuterol is an inhaled medication used to treat asthma and COPD. There was no labeling on the albuterol inhaler to indicate the name of the resident this inhaler was dispensed for. When asked, Nurse #7 stated she would need to discard the albuterol inhaler because it was not labeled with a resident's name. A review of Resident #40's July 2022 orders and Medication Administration Record (MAR) revealed the resident had a current order for the use of a 17 mcg / actuation Atrovent HFA inhaler.	F 761	Nurses, Staff Development Coordinator (SDC), Registered Nurse Supervisor, and the Unit Support Nurses audited all medication carts, treatment carts, and medication rooms two times weekly to identify any expired or undated medications. Corrections were made immediately where indicated. This was completed on 08/12/2022. No resident was found to be affected by the deficient practice. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 07/25/2022, the DON and SDC began educating all full time, part time, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Medication Aides including agency staff on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. " McNeill□s Pharmacy recommended storage for selected items. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled	

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F 761	Continued From page 95 However, she did not have a current order for an albuterol metered dose inhaler. An interview was conducted on 7/19/22 at 11:07 AM with the facility's Interim Director of Nursing (DON). During the interview, the DON stated, "All meds should have an identifier on it." He also reported that anything unlabeled was unsafe for both the administrator of the medication and the person receiving it. The DON stated he would want the nurse to discard these meds appropriately according to the facility guidelines. 2-a) An observation was conducted on 7/17/22 at 2:52 PM of the 300 Hall medication cart in the presence of Nurse #6. The observation revealed a medication vial containing a manufacturer ' s bottle of 0.4 milligrams (mg) nitroglycerin (a medication used to relieve angina or chest pain) sublingual (under the tongue) tablets was stored on the med cart. The pharmacy label on the medication vial indicated the nitroglycerin tablets were dispensed by an outside pharmacy for Resident #370. The manufacturer's labeling on the bottle of the nitroglycerin tablets indicated the medication ' s expiration date was October 2018. Upon review, the nurse confirmed the bottle of nitroglycerin sublingual tablets was expired. A review of Resident #370's July 2022 orders and Medication Administration Record (MAR) revealed the resident had a current order for 0.4 nitroglycerin sublingual tablet to be given as one tablet sublingually every 5 minutes as needed for angina (chest pain). Instructions for the medication included placing the tablet under the tongue and to let it dissolve all the way; give up to 3 doses in 15 minutes; if no relief after the first dose to contact the on-call provider; do not give if	F 761	in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the medication and treatment carts and the medication room is free of expired medications. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	

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F 761	Continued From page 96 the resident ' s blood pressure is less than 100/60. 2-b) An observation was conducted on 7/17/22 at 3:10 PM of the 100 Hall medication cart in the presence of Nurse #7. The observation revealed one stock bottle of 100 milligram (mg) docusate tablets (an over-the-counter stool softener) originally containing 100 tablets with approximately 50 tablets remaining was stored on the med cart. The manufacturer's expiration date printed on the bottle was June 2022. Upon review, the nurse confirmed the stock bottle of docusate tablets was expired. An interview was conducted on 7/19/22 at 11:07 AM with the facility's Interim Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated, "anything expired is unsafe for the administrator and the person receiving the medication." He reported all medications stored on the med cart should be within date. 3-a) An observation was conducted on 7/17/22 at 3:10 PM of the 100 Hall medication cart in the presence of Nurse #7. The observation revealed an opened 3.7 milliliter (ml) metered dose spray bottle of 200 units / actuation calcitonin (a nasal spray medication used to treat osteoporosis) dispensed on 4/23/22 for Resident #63 was stored on the med cart. The bottle was not dated as to when it had been placed on the med cart. However, the manufacturer labeling and a pharmacy auxiliary sticker indicated the medication needed to be refrigerated until opened/used. The pharmacy auxiliary sticker instructed, "Discard in 35 days after date opened."	F 761		

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According to Lexi-Comp, a comprehensive electronic medication database, an unopened bottle of calcitonin nasal spray should be stored under refrigeration at 36 degrees Fahrenheit (o F) to 46 o F. After opening, the bottle may be stored for up to 35 days at room temperature of 59 o F to 86 o F.

A review of Resident #63's medical record revealed he had a current order for 200 units / actuation calcitonin nasal spray.

3-b) An observation was conducted on 7/18/22 at 8:45 AM of the 100/200 Med Storage Room in the presence of the facility ' s Long Term Care (LTC) Unit Manager.

The observation revealed an opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. The vial was not labeled as to when it had been opened. When asked, the Unit Manager reported she would need to discard the vial of the Tuberculin PPD injectable medication due to not knowing when the vial had been opened.

The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days.

An interview was conducted on 7/19/22 at 11:07 AM with the facility's Interim Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated his expectations included ensuring a

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F 761	Continued From page 98 medication was labeled with the date it was opened so the medication ' s expiration date could be determined appropriately.	F 761		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, residents and staff interviews, the facility failed to obtain and honor residents' food preferences for 3 of 3 residents (Residents #4, #55, #58) reviewed for food choices/preferences. Findings included: 1. Resident #4 was originally admitted to the facility on 12/5/18 and re-admitted on 8/9/21 with diagnoses which included diabetes mellitus. The physician's order dated 2/8/22 revealed Resident #4 received a low concentrated sweet diet of soft, bite sized texture with minced and moist meats. The quarterly minimum data set (MDS) dated 4/18/22 indicated Resident #4 was cognitively	F 806	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F806 1. Corrective action Based on meal observations and interviews on 7/18/2022 the facility failed to obtain and honor food preferences for 3 of 3 residents. It was observed resident	8/14/22

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F 806	Continued From page 99 intact and received a therapeutic/ mechanically altered diet. A review of the clinical records indicated there was no food preferences documentation maintained for Resident #4 prior to 7/18/22. During an interview on 7/18/22 at 11:33 a.m. Resident #4 stated that she was "tired" of receiving cooked rice and mashed potatoes everyday during lunch and supper. She revealed she was not allowed to choose food items she preferred. She was unaware the facility offered a select, choice menu. She revealed someone from dietary talked with her that morning (7/18/22) about her food likes and dislikes. On 7/19/22 a.m. at 10:00 a.m. the Dietary Manager (DM) revealed the facility changed its' food service caterer and the menus on 7/6/22. She indicated the previous food service caterer did not maintain the residents' food preference sheets. She stated she had not received any complaints from the residents concerning food choices. The DM stated that only residents receiving regular diets would receive the select choice menu allowing the resident to choose which food items he/she would like served the next day for lunch and supper. During an observation on 7/20/22 at 1:03 p.m. Resident #4 was sitting on the side of her bed with her untouched meal tray on the overbed table next to her. The plated meal consisted of a chopped meat, zucchini, and mashed potatoes. The resident revealed she did not want the meal which included "mashed potatoes" again. She stated she did not request anything else, instead ate the meal leftovers from a restaurant outing	F 806	#4 was served mashed potatoes after updating their food preference to not include mashed potatoes; during interview resident revealed she was served mashed potatoes or rice at every lunch and dinner meal. During interview resident #55 stated she never received the ability to select menu items and often received items she preferred not to receive. During interviews resident #58 stated she wanted items inconsistent with diet and requested a diet change which the facility failed to act upon. On 7/18/2022 the dietary manager visited Resident #4 to update food preferences. Speech last diet review for Resident #4 was on 7/17/2022; diet continues as recommended by speech. On 8/6/2022 Resident #55 visited and food preferences updated. Resident #58 completed a diet waiver and diet was modified to Regular diet and food preferences updated. Resident added to menu selection program. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All dietary staff in-serviced 7/18/2022 regarding accuracy of meals served and diet consistency policies. All dietary staff are to have competencies evaluated. All current entries in Traycard will be reviewed for accuracy and modified as needed by 8/14/2022. Menu selection program modified to ensure all residents	

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F 806	Continued From page 100 with her family member, the day before. 2. Resident #55 was admitted to the facility on 6/3/22 with diagnosis which included hypertensive heart and chronic kidney disease with heart failure, and end-stage renal disease. The physician's order dated 6/3/22 revealed Resident #55 received a liberalized renal diet of regular consistency. Resident #55's Food Preference Sheet dated 6/7/22 only included the resident's renal diet of regular consistency with thin fluids. The resident's food preferences and food dislikes were not recorded. The quarterly minimum data set dated 6/28/22 indicated Resident #55 was cognitively intact and received a therapeutic diet. During an interview on 7/18/22 at 9:01a.m. Resident #55 stated that since her admission to the facility she had not been able to choose the food items she preferred on the renal diet. On 7/19/22 a.m. at 10:00 a.m. the Dietary Manager (DM) revealed the facility changed its' food service caterer and the menus on 7/6/22. She indicated the previous food service caterer did not maintain the residents' food preference sheets. She stated she had not received any complaints from the residents concerning food choices. The DM stated that only residents receiving regular diets would receive the select choice menu allowing the resident to choose which food items he/she would like served the next day for lunch and supper.	F 806	cognitively appropriate receive menu selections and are assisted as needed with program. All residents will be interviewed to update food preferences by 8/14/2022. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director on 7/18/2022. Topics included: ¿ Tray Accuracy Education ¿ Diet Consistency and Accuracy Policies ¿ Meal Service Policies ¿ Meal Selection Program Process This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Traycard to be reviewed and modified on admissions, quarterly, and as needed by Dietary Service Director. Menus to be reviewed daily and modified per diet preferences as needed by Dietary Service Director. 4. Quality Assurance monitoring procedure. The Dietary Services Director will monitor accuracy of completed trays served to residents per Dietary Meal QA Audit weekly x4 and then monthly x 2. Traycard will be audited monthly and test trays completed monthly per policy by the	

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F 806	Continued From page 101 During a second interview on 7/21/22 at 9:01 a.m., Resident #55 indicated she received a liberalized renal diet. She stated that she was aware there were different menu options within the renal diet and had been educated by the registered dietician at the dialysis center on food items she could and could not eat and on how to prepare renal diet menus. Resident #55 stated she was not given the option of the facility's select/choice menu as were the other residents. She also stated no one from the facility discussed her food preferences with her. On 7/21/22 at 9:49 a.m., the telephone interview with the Registered Dietician (RD#1) revealed she was covering remotely for the Registered Dietician assigned to the facility. RD#1 stated the resident's food preferences should have been honored within the renal diet restrictions. She stated the resident was seen weekly by the RD at the dialysis center who educated the resident on the consequences of not following the renal diet. She indicated dialysis centers were very inflexible about residents requesting altering their diets. 3. Resident #58 was admitted to the facility on 6/20/22 with diagnoses that included, in part, end stage renal disease and diabetes. The admission Minimum Data Set assessment dated 6/26/22 revealed Resident #58 was cognitively intact. The comprehensive care plan, updated 7/6/22, included a focused area of nutrition with interventions that stated, "receiving therapeutic diet and RD to evaluate and make diet change recommendations as needed."	F 806	Dietary Service Director. The consultant dietitian will complete quarterly diet orders. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director and/or Dietitian. Compliance will be monitored by the Ambassador Program daily and reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director. Compliance date: 08/14/2022	

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F 806	Continued From page 102	F 806		

A physician (MD) order dated 7/18/22 revealed Resident #58 was to receive a liberalized renal diet.

An interview was conducted with Resident #58 on 7/17/22 at 12:16 PM and on 7/20/22 at 1:43 PM. During the interview, the resident stated she was on a renal diet and received dialysis. She reported the facility had not given her a choice in what she could eat and had not provided a menu or approved list of substitutions for her therapeutic diet to select foods from when she requested it. She said when she asked for a menu, the staff replied she was on a strict renal diet and had not given her a menu. She added in the past she had requested tomatoes, cheese, spaghetti or lasagna and it was not provided to her because of the diet restriction. Resident #58 explained she understood that if she ate foods that were not consistent with the renal diet, it increased her phosphorus and potassium levels. She said she wanted the food items occasionally, not all the time and felt her rights were not honored and she was not permitted to make choices in what she ate. She further stated the facility had not educated her about the renal diet, but she had received information from her dialysis center about foods consistent with the renal diet.

On 7/19/22 at 9:27 AM an interview was completed with the Dietary Manager. She explained all residents on regular diets, with the exception of residents on renal diets, received a lunch and dinner choice menu that they completed during breakfast. The completed menu was returned to the kitchen with the breakfast trays and choices that were selected were provided on the meal trays the following

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F 806	Continued From page 103 day. She said residents who were on renal diets were not permitted to have items with high potassium and therefore, had not received the choice menu. The Dietary Manager recalled she had met with Resident #58, who requested tomato products but stated she can't give them to her until the RD or MD reviewed her medical record. During an interview with RD #1 on 7/20/22 at 10:08 AM, she explained she had filled in for the permanent RD and worked remotely when she completed nutrition assessments. She had not seen Resident #58 in person but had reviewed her medical record. She said the dialysis provider was typically inflexible with liberalizing a renal diet and when Resident #58 asked about liberalizing her diet, the dialysis center's provider denied the resident's request. The RD added if a resident was provided education about their diet and requested foods from the kitchen that were not consistent with the prescribed diet, the resident should be provided with the requested food and stated it was the resident's right to choose. RD #1 further stated she had not been consulted on changing Resident #58's diet and indicated there was not a list of approved substitutions within the prescribed liberalized diet. The Regional Vice President was interviewed on 7/20/22 at 10:42 AM and stated the facility should be asking residents for dietary preferences and then provide education regarding specific diets.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		8/14/22

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F 812	Continued From page 104 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen and nourishment refrigerators by not ensuring dishware were washed and rinsed at proper temperatures in the dishwashing machine; by not dating and labeling resealed food items; and by not ensuring food service equipment were clean and free from debris. The facility also failed to ensure food items not provided by the facility were dated, labeled with the resident's name and room number when stored in the snack/nourishment refrigerators in the 100/200 Hall nourishment room and in the main dining room. Findings included: 1. During the initial tour of the kitchen with the Dietary Manager (DM) on 7/17/22 at 10:07 a.m.,	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 7/17/2022. During initial walk through of the kitchen, it was noted dietary services had failed to	

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F 812	Continued From page 105 three wash and rinse cycles were observed during the operation of the high temperature dishwasher. The temperatures of each cycle read as followed: 1st wash reading was 168 degrees Fahrenheit and the final rinse reading was 140 degrees Fahrenheit; 2nd wash reading was 160 degrees Fahrenheit and the final rinse reading was 140 degrees Fahrenheit; and the 3rd wash reading was 169 degrees Fahrenheit and the final rinse reading was 138 degrees Fahrenheit. When questioned on the temperature requirements of the dishwasher, Dietary Staff #1 stated the wash temperature should read 165 degrees Fahrenheit and the final rinse cycle should read 180 degrees Fahrenheit. She stated the dishwasher temperatures were checked for accuracy during the second prewash cycle, before dishware were placed in the machine. Dietary staff #1 and the DM did not look at the temperature gauges on the dishwasher throughout the three observations. The temperatures of the three observations of the final rinse cycles were below the minimum requirement of 180 degrees Fahrenheit. This surveyor informed the dietary staff member and the DM the three crates of tray lid covers and food trays would have to be rewashed and rinsed due to the decreased rinse temperatures. The DM stated she would immediately notify the dishwasher vendor for repair and until repaired, all dishware would be washed in the dishwasher then rinsed and sanitized in the three-compartment sink. 2. On 7/17/22 at 10:20 a.m. observations of the food storage areas in the kitchen revealed resealed and opened food items that were not dated and labeled and/or left uncovered. There	F 812	identify improper dish machine temperatures, reseal open container of grapes in walk-in fridge, date/label multiple items in the walk in freezer (1 bag of breadsticks, 1 box pulled chicken, 1 box of omelets), and date/label multiple items in dry storage (1 bag resealed jello, 1 container apple pie filling, and bag of couscous). During the tour food residue and stains were found around 1 double sealed container in dry storage, microwave, ingredient bins, and fry wire baskets on top of fryer. During observation of nourishments rooms and dining room 1 of 2 nourishment refrigerator/freezer and the main dining room refrigerator/freezer were noted to have items without labels and dates (med pass containers, container Ensure, 1 opened box icy snacks, 5 16oz diet sodas, 1 box pastries, and 1 gallon ice-cream). On 7/17/2022 Dietary Service Director discarded any improper closed food and non-labeled/dated food items in the kitchen and nourishment fridges. Vendor contacted for dish machine repair and dish machine 7/17/2022. Cleaning list was established to clean items cited; cleaning complete 7/18/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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F 812	Continued From page 106 was 1-(6-inch deep) pan covered with cellophane pan of unidentifiable cooked, chopped meat that was not labeled or dated in the reach-in refrigerator. One serving scoop was placed in a 6-inch deep pan of pureed bread covered with cellophane in the serving line refrigerator. The walk-in refrigerator contained 1-open box of red grapes. The walk-in freezer contained 1-resealed bag of breadsticks not dated/labeled; 1-opened box of pulled chicken not dated; and 1-open box of omelets. In the dry storage room there was 1-resealed bag of jello mix not dated or labeled; 1-(18 pound) container of resealed apple pie filling not dated and with a brown, sticky substance around the lid's closing; 1-double sealed, resealed bag of couscous that was not dated or labeled. 3. During a tour of the kitchen on 7/17/22 at 10:22 a.m, the inside of the microwave oven revealed yellow food crumbs and stains. The Assistant Dietary Manager indicated the microwave was last utilized 1-2 days prior. There were food stains on the inside and outside of the food warmer. The lids of the large sugar bin and the table top sugar bin were covered with white grainy particles. There were 2-wire baskets containing large pieces of fried food items on top of the deep fryer. The Assistant Dietary Manager revealed the deep fryer was used the night before and the staff should have cleaned it. 4. On 7/20/22 at 1:03 p.m. the refrigerator/freezers in 1 of 2 nourishment rooms and in the main dining room was observed with resealed food items that were not dated, labeled with a resident's name and room number, and	F 812	On 7/17/2022, the Dietary Service Director completed a kitchen and nourishment walk through to ensure all food items were within their dates and dated properly. The maintenance director complete a walk through of the kitchen to check all equipment was in working order and meeting manufacture recommended temperatures. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Storage and dating policies and regulations. " Proper cleaning and sanitation regulations. " Temperature regulations. " Procedures for alerting PIC when equipment out of working order. " Inspections on shifts to observe all food are within their dates and tossed if out of date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure.	

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F 812	Continued From page 107 outdated, resealed items. The 100/200 hall nourishment room's refrigerator/freezer contained 2-(32 ounce) resealed containers of med plus 1.7 (nutrition drink) with a sticker date of 5/31/22, but the directions on the containers indicated the drinks were to be used within 3 days of opening. There was also 1(8 ounce) resealed container of Ensure (nutrition drink) without a resident's name or date opened. In the freezer there was 1-open box of multiple single serve icy treats without a resident's name.The dining room's refrigerator/freezer consisted of 5(16 ounce) bottles of diet sodas that were not dated or labeled with a resident's name. The freezer contained:1-box of pastries that were not dated or labeled with a resident's name and of 1-gallon of resealed ice cream not dated and labeled with a resident's name. During an interview on 7/20/22 at 4:30 p.m. the Dietary Manager stated the dietary department was responsible for maintaining the 2-nourishment rooms on the residents' halls which were checked everyday between 1:00 p.m. and 1:30 p.m. She revealed dietary was not responsible for the refrigerator in the dining room and she was unaware of which department maintained the dining room refrigerator.	F 812	The Dietary Service Director or designee will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Compliance date: 08/14/2022	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		8/18/22

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F 880	Continued From page 108 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 109 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 and staff interviews, the facility failed to implement a Legionella prevention program. This had the potential to affect all 74 residents who resided in the facility. The findings included: A review of the facility ' s Emergency Preparedness and Infection Control Programs revealed the facility had not implemented water safety management for Legionella. On 7/21/22 at 3:01 PM, an interview was conducted with the Maintenance Director. He stated the previous administrator called him into the office one day last week and they had a training video about the water safety program. He stated the facility didn ' t know about it and had not been doing anything about it. He stated they	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 880	Continued From page 110 received the policy, but no action has been taken.	F 880	On 7/13/2022 the Infection Control Policy and Procedure-Water Safety Policy was updated by the Corporate Chief Nursing Officer to address identification and treatment for Legionella within the facility water system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 08/11/2022, The Corporate Regional Maintenance Director completed a Water Management Risk Assessment for the facility to identify any risk areas. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: The Director of Nursing (DON) and Staff Development Coordinator (SDC) began education with all staff including all facility Registered nurses, Licensed practical nurses, medication aides, nursing aides, nonclinical staff, department heads, therapy department, environmental services, maintenance and dietary staff on 08/11/2022 on the facility water management program, which includes Legionella and the steps taken to reduce the risk of growth and spread of Legionella. On 08/11/2022, the DON and SDC	

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F 880	Continued From page 111	F 880	initiated validation of competency of the water program. This will be completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: On 7/6/2022 the Administrator or designee will observe and monitor facility water safety using QA screening tool for F880 Water Safety- Legionella weekly x 5 weeks then monthly x 2 months to ensure that facility infection control policy related Legionella is in compliance. Quality Assurance (QA) Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality	

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F 880	Continued From page 112	F 880	Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 08/18/2022 Directed Plan of Correction Compliance Date: 08/18/2022 Root Cause Analysis: A root cause analysis was completed on 08/11/2022 by the: Infection Preventionist who is certified in infection control, DON, and the Quality Assurance Nurse Consultant and was reviewed by the Performance Improvement (QAPI) committee on 08/12/2022. A safety meeting was held on 08/12/2022 to discuss ongoing implementation of the water management program. This Root Cause Analysis will be a part of our ongoing Performance Improvement Process. The root cause analysis was incorporated into the plan of correction/intervention plan. On 08/11/2022, the DON and SDC initiated validation of competency of the water program. This will be completed by 08/18/2022. Attestation Statement I attest that I have completed a course in Infection Control. I am the Director of	

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F 880	Continued From page 113	F 880	Nurses/an Infection Preventionist having completed a course on Infection Control from NC SPICE. I have provided education on Legionella Prevention Program as described in the Plan of Care for F880 at Summerstone Health and Rehabilitation Center. Topics included: " Developing a Water Management Program to reduce Legionella Growth and Spread in Buildings. Education sessions were completed by each staff member utilizing the PPE Education. In-service dates and times include: August 11, 2022 02:00 pm □ 9:00 pm August 12, 2022 09:00 am □ 3:30 pm This is ongoing and will be completed 08/18/2022 Those that are not able to attend the in-service training will be phoned and provided the education over the phone. On 08/18/2022, any employee who has not received this education will not be allowed to work until the training has been completed. This includes all facility staff in all departments and Licensed nurses Registered Nurses (RN) and Licensed Practical Nurse (LPN) and Certified Nursing Assistants (CNA) medication aides, nonclinical staff, department heads, therapy department, environmental services, maintenance, and dietary staff	

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F 880	Continued From page 114	F 880	full time, part time, and PRN staff including agency staff. The in-service will be incorporated into the new employee facility orientation. Printed Name: Mariolyn Clarillo, RN Signature: Mariolyn Clarillo, RN Credentials: NC Spice Certified Date: 08/12/2022	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any	F 887		8/18/22

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F 887	Continued From page 115 additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document the correct date of a Covid-19 vaccination which affected the resident being offered a booster dose for 1 of 5 residents	F 887	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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F 887	Continued From page 116 (Resident #55) reviewed for vaccination history. The findings included: Resident #55 was admitted to the facility on 6/3/2022. A review of Resident #55's discharge summary from the hospital, dated 6/3/2022, documented her immunization history to include COVID-19 Pfizer dose 1 on 5/12/2021 and COVID-19 Pfizer dose 2 on 6/1/2021. A review of Resident #55's electronic medical record at the facility, under the immunization tab documented the second dose of COVID-19 history as 6/1/2022 rather than 6/1/2021 as indicated on the hospital discharge summary. Resident #55's electronic medical record revealed she tested positive for COVID-19 on 7/6/2022. An interview was conducted on 7/21/2022 at 2:17 p.m. with the Assistant Director of Nursing, the facility infection preventionist, and she reviewed Resident #55's electronic medical record and stated her vaccination date of the second dose of COVID-19 was on 6/2/2022. She reviewed the hospital discharge summary and stated the documented date was 6/1/2021 and that the date entered into the electronic medical record at the facility appeared to be a data entry error. She added that a booster dose of COVID-19 had not been offered to the Resident due to the data entry error, because a booster dose had not appeared to be due at the time.	F 887	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F887 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: 1. Corrective action for resident(s) affected by the alleged deficient practice: A corrective action was obtained for Resident #55 on 08/11/2022 when the residents immunization record was updated to reflect the accurate date of his 2nd COVID Vaccine. On 08/12/2022, the Registered Nurse Supervisor offered the resident her additional booster. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 08/10/2022 the Staff Development Coordinator who is the Infection Preventionist and the Unit Support Nurse initiated an audit of 100% of the current residents vaccination records comparing the vaccination card with the information in the Electronic Medical Records. The facility has scheduled a date for an upcoming vaccine clinic. This was	

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F 887	Continued From page 117	F 887	completed on 08/11/2022. On 08/10/2022, Any records that required updating were updated and residents who meet criteria for a dose were offered the vaccine. This will be completed on 08/18/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/11/2022 the Quality Assurance Nurse Consultant began education with the Director of Nurses (DON), SDC, Unit Support Nurse, Registered Nurse Supervisor, and the Minimum Data Set (MDS) Nurse on COVID Vaccine Policy for residents. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be	

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F 887	Continued From page 118	F 887	completed by the Director of Nurses or designee to monitor that COVID Vaccine information is accurately recorded using the F887 Quality Assurance Tool. Monitoring of 6 residents to ensure compliance with procedure for recording COVID Vaccine Data. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		8/18/22

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F 947	Continued From page 119 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete required dementia care training and abuse prevention training for 3 of 3 current nursing staff (Nursing Assistants #3, #4, and #5.) Findings included: 1. Nursing Assistant (NA) #3's date of hire was 2/15/21. A review of the facility's inservice records and transcript report from the facility's online training program revealed NA #3 had not completed any dementia care training or abuse prevention training in the past 12 months. In an interview with the Corporate Floating Director of Nursing (DON) on 7/21/22 at 9:19 AM, she shared that dementia care training and abuse prevention training were completed through the facility's online training academy. She said the computer system auto populated for the employee to complete the training. She added the corporate office monitored the completion of courses and sent emails to staff when trainings needed to be completed. She said NA #3 had been notified by the corporate office that the trainings needed to be completed since the	F 947	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F947 1. Corrective action for resident(s) affected by the alleged deficient practice: On 07/25/2022, in-services were scheduled to notify staff of the requirement to complete required dementia care training and abuse prevention training annually. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 947	Continued From page 120 Center for Medicare and Medicaid Services (CMS) waiver for education that had been in effect for the public health emergency had expired. The Interim DON was interviewed on 7/21/22 at 2:56 PM and stated the clinical team encouraged staff members to complete the required education and trainings and meet the deadlines. 2. NA #4's date of hire was 12/28/20. A review of the facility's inservice records and transcript report from the facility's online training program revealed NA #4 had not completed any dementia care training or abuse prevention training in the past 12 months. In an interview with the Corporate Floating Director of Nursing (DON) on 7/21/22 at 9:19 AM, she shared that dementia care training and abuse prevention training were completed through the facility's online training academy. She said the computer system auto populated for the employee to complete the training. She added the corporate office monitored the completion of courses and sent emails to staff when trainings needed to be completed. She said NA #4 had been notified by the corporate office that the trainings needed to be completed since the Center for Medicare and Medicaid Services (CMS) waiver for education that had been in effect for the public health emergency had expired. The Interim DON was interviewed on 7/21/22 at 2:56 PM and stated the clinical team encouraged staff members to complete the required education and trainings and meet the deadlines.	F 947	100% audit of the training records were reviewed to identify certified nursing assistants who had not met the requirement to complete the required dementia care training and abuse prevention training. Any staff who hadn□t completed the required training were notified of the staff requirement to complete the training. This will be completed by 08/18/2022. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 07/25/2022, the Director of Nurses (DON) and the Staff Development Coordinator (SDC) began education of all full time, part time, and prn certified nursing assistants that in-service training must 483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. 483.95(g)(2) Include dementia management training and resident abuse prevention training. 483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at 483.70(e) and may address the special needs of residents as determined by the facility staff. 483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. Annual training is required and must be completed. This in-service was incorporated in the new employee facility orientation for the	

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F 947	Continued From page 121 3. NA #5's date of hire was 9/12/19. A review of the facility's inservice records and transcript report from the facility's online training program revealed NA #5 had not completed any dementia care training or abuse prevention training in the past 12 months. In an interview with the Corporate Floating Director of Nursing (DON) on 7/21/22 at 9:19 AM, she shared that dementia care training and abuse prevention training were completed through the facility's online training academy. She said the computer system auto populated for the employee to complete the training. She added the corporate office monitored the completion of courses and sent emails to staff when trainings needed to be completed. She said NA #5 had been notified by the corporate office that the trainings needed to be completed since the Center for Medicare and Medicaid Services (CMS) waiver for education that had been in effect for the public health emergency had expired. The Interim DON was interviewed on 7/21/22 at 2:56 PM and stated the clinical team encouraged staff members to complete the required education and trainings and meet the deadlines.	F 947	above-mentioned employees. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F947 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved by the QAPI Committee. Audits will occur to assure required nurse aid training is completed. This will include auditing 100 % employees to ensure training has been completed. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	