STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345568	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG	83 CAVALIER DRIVE, STE 200 WILMINGTON, NC 28405

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E 000	Initial Comments An unannounced recertification survey was conducted from 07/10/22 through 07/27/22. The facility was found to be in compliance with CFR 483.73 Emergency Preparedness. Event ID #CRLA11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 07/10/22 through 07/27/22. Event ID# CRLA11. Substandard quality of care (SQC) was identified at: CFR 483.24 at tag F680 at a scope and severity (F) An extended survey was conducted.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		8/19/22

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

Electronically Signed | 08/18/2022

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(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)

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F 636	Continued From page 2 (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) comprehensive admission assessment for 1 of 16 residents (Resident #68) reviewed. Findings included: Resident #68 was admitted to the facility on 06/28/22 with diagnoses of dementia. The MDS admission assessment date was dated 07/05/22 and indicated "in process." An interview with the MDS Nurse on 07/13/22 at 1:45 PM was conducted. The MDS Nurse stated she was aware the assessment needed to be completed within 14 days of the day of admission date of 06/28/22 and she was working on it. The MDS nurse stated she has been having to work between the two campus ' s and she got behind on her assessments and added the assessment should have been completed on 07/12/22. An interview was conducted with the Administrator on 07/13/22 at 6:00 PM. The Administrator stated her expectation of the MDS Nurses was to complete the comprehensive assessments on time. The Administrator added the timeliness of the assessments drives the care area assessments and care plans, so the assessments needed to be completed on time to accurately reflect the care of the residents.	F 636	Davis Health and Wellness Center of Cambridge Village acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Davis Health and Wellness Center of Cambridge Village□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Davis Health and Wellness Center of Cambridge Village reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F636 1. The identified comprehensive admission assessment was completed for resident # 68 on 7/26/22. 2. Other residents with scheduled comprehensive admission assessments were reviewed and completed as appropriate. 3. Staff was retrained regarding expectation of completion of MDS assessment on 7/29/22. 4. The Administrator or designee will	

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F 636	Continued From page 3	F 636	audit the completion of MDS assessments weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the required Significant Change in Status Assessments (SCSA) for 2 of 16 residents (#9, #3) reviewed for assessments. Resident #9 required SCSA due to changes in activities of daily living and incontinence patterns. Resident #3 required SCSA due to election of hospice benefits. The findings included: 1.Resident #9 was admitted on 9/16/21 with medical diagnoses which included in part congestive heart failure, hypertension, and neuropathy (nerve damage).	F 637	F637 1. The identified comprehensive assessments after significant change were completed for resident #9 and 3 on 7/29/22. 2. Other residents with comprehensive assessments after significant change were reviewed and completed as appropriate. 3. Staff was retrained regarding expectation of completion of MDS assessment on 7/29/22. 4. The Administrator or designee will audit the completion of MDS assessments	8/19/22

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F 637	Continued From page 4 Review of the quarterly Minimum Data Set (MDS) assessment dated 3/1/22 revealed resident had moderate cognitive impairment, required limited assistance with bed mobility and toileting and transfers did not occur. Resident #9 required supervision with eating, had minimal difficulty hearing and was always incontinent of bowel and bladder. Review of Resident #9's quarterly MDS assessment dated 5/26/22 revealed resident had moderate cognitive impairment and required extensive assistance with bed mobility, transfers and toileting. Resident was able to feed self with supervision after set up assistance. Resident #9 had minimal difficulty hearing and was frequently incontinent of bowel and bladder. A review of the MDS assessments for Resident #9 indicated that a Significant Change in Status Assessment (SCSA) was not completed within 14 days of the identification of changes in two or more activities of daily living (ADL's) including increased assistance with bed mobility and toileting as well as a change in incontinence patterns from always incontinent to frequently incontinent. Interview with MDS Nurse on 7/13/22 at 1:30 PM revealed that she was aware of the Long-Term Care Facility Resident Assessment Instrument user's manual indications regarding identifying and completing significant change assessments. She stated that the significant change assessment for Resident #9 should have been completed based on a comparison of the current status to the prior assessment.	F 637	weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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F 637	Continued From page 5	F 637		

2. Resident #3 was admitted to facility on 3/7/22 with medical diagnoses which included in part: open wound to left leg, osteomyelitis, pressure ulcer, chronic obstructive pulmonary disease, and neuropathy (nerve damage).

Review of Resident #3's 3/11/22 Admission Minimum Data Set (MDS) assessment revealed hospice services was not checked. Resident #3 was coded as cognitively intact on the assessment.

Review of Resident #3's medical record revealed a document labeled Election of Hospice benefit which the resident signed and dated 3/14/22.

Review of Resident #3's MDS assessments dated 3/11/22 and 6/11/22 indicated a SCSA had not been completed within 14 days of her admission to hospice care.

An interview was conducted with the MDS Nurse on 7/13/22 at 1:30 PM. She confirmed that Resident #3 elected the hospice benefit on 3/14/22 and the services were ongoing. A review of the MDS assessments that indicated a SCSA had not been completed within 14 days of her admission to hospice was reviewed with the MDS Nurse. She indicated that a SCSA MDS assessment should have been completed within 14 days of Resident #3's admission to hospice. MDS nurse indicated that she did not know why the SCSA MDS assessment had not been completed after Resident #3 elected the hospice benefits. MDS Nurse stated that additional staff had been hired to assist with MDS assessments however they had left unexpectedly. The MDS Nurse indicated that because of the staffing changes the facility had been having difficulty

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F 637	Continued From page 6 completing the MDS assessments. The MDS Nurse stated that it was important to complete significant change assessments as part of the care planning process and to address resident's needs accurately. An interview was conducted with the Administrator on 7/13/22 at 5:55 PM. She indicated that it was her expectation that all MDS assessments were completed accurately and timely per the Long-Term Care Facility Resident Assessment Instrument User's manual.	F 637		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required 14-day timeframe for 1 of 16 residents reviewed for MDS assessments (Resident #3). Findings included: Resident #3 was admitted to facility on 3/7/22. Review of Resident #3's Minimum Data Set (MDS) assessments revealed an Admission assessment was completed with an assessment reference date of 3/11/22. Review of Resident #3's quarterly MDS	F 638	F638 1. The identified quarterly MDS assessment was completed for resident # 3 on 7/26/2022. 2. Other residents with quarterly assessments were reviewed and completed as appropriate. 3. Staff was retrained regarding expectation of completion of MDS assessment on 7/29/22. 4. The Administrator or designee will audit the completion of MDS assessments weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	8/19/22

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F 638	Continued From page 7 assessment dated 6/11/22 revealed the assessment was listed as in process, or incomplete. The MDS had an assessment reference date (ARD) of 6/11/22 and was incomplete as of 7/13/22. This was 33 days after the ARD. An interview was conducted on 7/13/22 at 1:30 PM with the MDS Nurse. The MDS Nurse indicated that the quarterly MDS assessment dated 6/11/22 was late and that she was working on it. The MDS Nurse indicated that she was having to complete assessments for both campuses and was behind. The MDS Nurse stated that it was important to complete the required assessments timely as part of the care planning process and to address resident's needs accurately. An interview with the Director of Nursing (DON) was conducted on 7/13/22 at 2:00 PM. The DON indicated that she was not aware that the quarterly assessment for Resident #3 was late. An interview was conducted with the Administrator on 7/13/22 at 5:55 PM. She indicated that it was her expectation that all MDS assessments were completed on time. The Administrator stated that the timeliness of the assessments impacted the care plans. She added that the assessments needed to be completed on time to accurately reflect the care of the residents.	F 638		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		8/19/22

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F 641	Continued From page 8 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 Data Set (MDS) assessment to include anticoagulant use for 1 of 5 residents (Resident #5) reviewed for unnecessary medications. Findings included: Resident #5 was admitted to the facility on 02/05/16. Diagnoses included, in part, chronic embolism and thrombosis of lower extremity. The MDS quarterly assessment dated 04/14/22 revealed Resident #5 was severely cognitively impaired. The MDS indicated Resident #5 did not receive any anticoagulants (a medication to thin blood and prevent blood clots) during this assessment. A physicians' order written on 01/19/18 for Eliquis (anticoagulant) 5 milligrams (mg) to be given twice per day. The Medication Administration Record revealed Resident #5 received the medication Eliquis 5mg twice per day from 04/01/22 through 04/14/22 as evidenced by nursing initials. An interview was conducted with Nurse #2 on 07/12/22 at 11:18 AM. Nurse #2 stated Resident #5 was on Eliquis and had been since she was admitted. An interview was conducted with the MDS Nurse on 07/13/22 at 2:00 PM. The MDS Nurse revealed she should have coded Resident #5 for	F 641	F641 1. The identified inaccurate assessment was corrected to include anticoagulant use for resident #5 on 7/22/22. 2. Other residents with anticoagulant therapy were reviewed for accuracy on the MDS and corrected as appropriate. 3. Staff was retrained regarding expectation of completion of MDS assessment 7/29/22. 4. The Administrator or designee will audit the completion of MDS assessments weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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F 641	Continued From page 9 the anticoagulant use, but she overlooked it. An interview was conducted with the Administrator on 07/13/22 at 6:00 PM. The Administrator stated she expected the MDS nurse to code the assessments accurately to reflect the care of the residents.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		8/19/22

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F 656	Continued From page 10 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive care plans according to the care area assessments (CAA) for 3 of 16 residents reviewed. (Resident #8, #9, and #10). Findings included: 1) Resident #8 was readmitted to the facility on 05/03/22. Diagnoses included, in part, Alzheimer ' s dementia, urinary tract infection, chronic pain and depression. The MDS admission assessment dated 05/05/22 revealed the resident was moderately cognitively impaired, demonstrated behaviors of rejection of care, and was always incontinent of bowel and bladder. She received 2 insulin injections, 3 days of antipsychotic medication, 3 days of antidepressant medication, and 3 days of antibiotic medication during this assessment. The care area assessments (CAAs) for the MDS assessment dated 05/05/22 revealed urinary incontinence, behaviors, falls and psychotropic	F 656	F656 1. The identified care plan not addressing care area assessments use were corrected for resident # 8 on 8/11/22. The identified care plan not addressing care area assessments for communication for resident #9 was corrected on 8/9/22 and for incontinence on 7/28/22. The identified care plan not addressing care area assessments for resident #10 for incontinence was corrected 8/11/22, corrected for behaviors on 8/10/22 and for activities and psychotropic medication on 7/22/22. 2. Other residents CAA□s noted as proceeding to care plan were reviewed and care plans corrected as appropriate. 3. Staff was retrained regarding expectation of completion of MDS assessment 7/29/22. 4. The Administrator or designee will audit the completion of MDS assessments weekly for 8 weeks. The findings will be reported to the QAPI committee for review	

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F 656	Continued From page 11 drug use were selected to have a care plan in place. Resident #8 ' s care plan dated 05/05/22 revealed there was no care plan for urinary incontinence, behaviors, falls or psychotropic drug use. An interview with the MDS Nurse on 07/13/22 at 1:45 PM revealed the CAAs trigger for a care plan to be developed as a result of the information that she would put into the electronic record based on orders, progress notes, and medication review. The MDS Nurse stated Resident #8 should have a care plan in place for cognition, urinary incontinence, falls and psychotropic use since they triggered on the CAAs. The MDS nurse stated she should have developed the care plans and overlooked it. An interview with the Administrator on 07/13/22 at 6:00 PM revealed if any care plans were indicated to be developed in the CAA section, she would expect the MDS Nurse to develop and implement those care plans, so the plan of care accurately reflects the residents. 2) Resident #9 was admitted on 9/16/21 with diagnoses which included in part: congestive heart failure, hypertension, and neuropathy (nerve damage). Review of Resident #9's admission assessment dated 9/22/21 revealed the following care area assessments (CAAs): cognition, communication, incontinence, falls and pressure ulcers. The care plan decision was checked to proceed to care plan to address the following areas: cognition, communication, incontinence, falls and pressure ulcers.	F 656	of performance improvement monthly for 3 months	

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Review of Resident #9's care plan with a start date of 9/27/21 revealed the following problems were addressed in the care plan: cognitive loss, falls, psychosocial wellbeing, pressure ulcer, activity of daily living, nutrition and pain. Communication and incontinence were not addressed.

An interview was conducted with the MDS Nurse on 07/13/22 01:53 PM. The MDS Nurse revealed that if a CAA was triggered by the MDS and the decision was made to proceed to care plan, that a problem, goal, and interventions should be in the care plan. After reviewing Resident #10's care plan with the MDS Nurse, she confirmed that communication and incontinence were still active problems for this resident, and she did not know why the areas listed in the CAA's that were to be included in the care plan were not there.

An interview with the Administrator on 07/13/22 at 5:55 PM revealed if the CAA section indicated that an area was to be addressed in the care plan, she would expect the MDS Nurse to develop and implement those care plans. She added that she expected the plan of care to accurately reflect each resident.

3). Resident #10 was admitted on 5/6/22 with diagnosis which included in part falls, cognitive/communication deficit, pain, hypertension, anxiety.

Review of Resident #10's 5/9/22 Admission Minimum Data Set assessment revealed resident had minimal difficulty with hearing, had minimal cognitive impairment, required limited assistance of 2 people with bed mobility, transfers and toileting. Resident #10 was able to feed herself

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with set up assistance and was occasionally incontinent of bowel and bladder.

Review of the Significant Change in Status Assessment (SCSA) dated 5/26/22 revealed Resident #10 had minimal difficulty hearing, was cognitively intact, and required assistance with bed mobility, transfers, and toileting. Resident #10 demonstrated rejection of care and was not interested in activities with groups of people. She received 3 days of antianxiety medication and 7 days of antidepressant. The care area assessments from the SCSA MDS assessment dated 5/26/22 revealed cognition, vision, communication, Activity of Daily Living (ADL), incontinence, psychosocial, behavior, activities, falls, pressure ulcers, and psychotropic medication. The care plan decision was marked as proceed to care plan for the following areas: cognition, communication, ADL, incontinence, psychosocial, behavior, activities, falls, pressure ulcers, and psychotropic medication.

Review of Resident #10's care plan dated 5/26/22 revealed that there was no care plan for incontinence, behavior, activities and psychotropic medication.

An interview was conducted with the MDS Nurse on 07/13/22 01:53 PM. The MDS Nurse revealed that if a CAA was triggered by the MDS and the decision was made to proceed to care plan, that a problem, goal, and interventions should be in the care plan. After reviewing Resident #10's care plan with the MDS Nurse, she stated she did not know why the areas listed in the CAA's that were to be included in the care plan were not there.

An interview with the Administrator on 07/13/22 at

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F 656	Continued From page 14 5:55 PM revealed if the CAA section indicated that an area was to be addressed in the care plan, she would expect the MDS Nurse to develop and implement those care plans. She added that she expected the plan of care to accurately reflect each resident.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		8/19/22

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F 657	Continued From page 15 Based on record review and staff interviews the facility failed to provide the resident and/or resident representative with a care planning conference to participate with the interdisciplinary team and Hospice in the development of a comprehensive care plan for 1 of 16 residents (Resident #3) reviewed for care plans. The findings included: Resident #3 was admitted to the facility on 3/7/22 with medical diagnoses which included: open wound to left leg, osteomyelitis (inflammation of the bone usually due to infection), pressure ulcer, chronic obstructive pulmonary disease, and neuropathy (nerve damage). Review of Resident #3's 3/11/22 Admission Minimum Data Set (MDS) assessment revealed resident was cognitively intact, required extensive assistance with bed mobility, transfers and toileting and had two areas of skin breakdown. Review of the record for Resident #3 revealed that she elected the Hospice benefit on 3/14/22. Interview with Resident #3 on 7/10/22 at 4:35 PM revealed that she had not been invited to participate in a care plan meeting. Resident #3 further stated that she was not aware that she was receiving Hospice services. There was no evidence in the medical record that an interdisciplinary care plan meeting for Resident #3 was held since she was admitted on 3/7/22. There was no evidence in the medical record that Resident #3, or her representative was invited to a care plan meeting since she was admitted on 3/7/22.	F 657	F657 1. The identified care planning conference for resident #3 was completed 8/17/2022. 2. Other residents care planning conferences were reviewed and completed as appropriate. 3. Staff was retrained regarding expectation of completion of MDS assessment on 7/29/22. 4. The Administrator or designee will audit the completion of MDS assessments weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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There was no evidence in the medical record of a Hospice Plan of Care or that Hospice had attended a facility care plan meeting.

Interview with the MDS Coordinator on 7/13/22 at 1:30 PM revealed that the Case Manager was responsible for inviting residents and /or resident representatives to the care plan meetings. MDS Coordinator stated that there was a new Case Manager who was only in the position for about a month. The MDS Coordinator was unable to provide evidence that a care plan meeting invitation had been extended to Resident #3 or her representative. MDS Coordinator was unable to explain why a care plan meeting had not been held. MDS Coordinator was unable to provide a copy of the Hospice Plan of Care. MDS Coordinator indicated that a Hospice Plan of Care should be available for Resident #3.

Interview with Director of Nursing (DON) on 7/13/22 at 2:30 PM revealed that the care plan meeting was to involve the resident and resident representative in the care planning process. DON was unable to provide evidence that a care plan meeting invitation was provided to Resident #3 or her representative. DON was unable to provide evidence that a care plan meeting was held for Resident #3 since admission on 3/7/22. The DON indicated that the expectation was that care plan meetings would be held at a minimum of every three months and that the resident and/or the representative would be invited to each meeting. DON further indicated that a Hospice care plan for each resident receiving Hospice services should be available in the facility to coordinate care. DON did not know why there wasn't one. DON revealed there was not a

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F 657	Continued From page 17 system in place to ensure that Hospice care plans were available for residents that received Hospice services. Interview with the Administrator on 7/13/22 at 5:55 PM revealed that she expected that residents and/or their representatives would be invited to care plan meetings at a minimum of every three months. She further stated that she expected that Hospice care plans were available in the facility for each resident that received Hospice services. The Case Manager was unavailable for interview due to illness.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews, and record review, the facility failed to develop and implement an activities program that included resident centered one on one (1:1) and group activities to meet the individual needs of residents for 1 of 1 cognitively impaired resident (Resident #68) reviewed for activities.	F 679	F679 1. The identified resident discharged home on 8/3/2022. Activity calendars were placed in resident rooms during the survey process. 2. Other resident MDS assessments were reviewed and completed as	8/19/22

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F 679	Continued From page 18 Findings included: Resident #68 was admitted to the facility on 06/28/22 with diagnoses that included dementia. The Minimum Data Set (MDS) admission assessment was dated 07/05/22 and indicated "in process." The activity assessment for preferences for customary routine and activities was not completed as of 07/13/22. Resident #68 had a baseline care plan in place and no activities were care planned. The comprehensive care plan was due to be completed on 07/12/22 and had not been completed as of 07/13/22. There was no evidence of an activities assessment or evaluation in the medical record. Additionally, there was no evidence of any documentation related to group activities attended by Resident #68 or 1:1 activities provided to the resident. Observations of rooms 1 - 20 during the tour on 07/10/22 at 12:30 PM revealed there were no activity calendars displayed in the residents ' rooms. During the initial tour on 07/10/22 at 12:15 PM, Resident #68 was noted to be in his bed eating his lunch. Resident #68 was noted to be alert but confused. Observations on 07/10/22 from 12:00 PM till 6:00 PM revealed there were no structured activities being conducted in the facility. There were 20 rooms in the facility and one dining	F 679	appropriate. Other care plans were reviewed and completed as appropriate. The group activity calendar was provided to residents with encouragement to attend. Activity participation/refusal log reviewed, revised to note resident preferences for activities. 3. Staff retrained regarding posting of activity calendars in room and strategies to encourage resident participation per resident preference on 8/19/22. 4. The Administrator or designee will audit the conducting of activities per the activity calendar weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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room/common area. The conference room, located off of the dining room, held activity supplies such as books, magazines, games, and puzzles. The common area adjacent to the dining room had a large screen TV, a piano, bird cage with birds, a radio, and a secured sun deck patio with table and chairs.

Observations of Resident #68 throughout the day revealed Resident #68 stayed in his room from 12:00 PM till 6:00 PM on 07/10/22.

An interview was conducted with a family member (FM) of Resident #68 on 07/10/22 at 4:45 PM. The FM stated Resident #68 was confused and could not make his needs known at all times, but she was concerned that whenever she would come to visit Resident #68 during the day hours or around dinner time, he would always be in his room and not participating in any activities. The FM stated she would visit daily during the afternoon hours and stay through dinner, and she had not ever seen any activities occur during her visits. The FM indicated she thought Resident #68 was lonely and needed more stimulation.

Observations during the hours of 8:30 AM through 5:00 PM on 07/11/22 of Resident #68 revealed the resident stayed in his room.

Observations from the conference room looking out to the dining room/common area (where activities would have been held) on 07/11/22 during the timeframe of 8:30 AM through 5:00 PM revealed there were no residents being brought out to the dining/common room area to participate in activities and no structured activities were observed.

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An interview with the MDS Nurse on 07/13/22 at 1:45 PM was conducted. The MDS Nurse acknowledged the MDS assessment that included the section for preferences for customary routine and activities for Resident #68 needed to be completed and she was working on completing the assessment. The MDS nurse stated she has been having to work between the two campuses and she got behind on her assessments.

An interview was conducted with Nurse #2 on 07/12/22 at 11:10 AM. Nurse #2 stated he had been working at the facility for a couple of years. He stated he was not agency staff. He reported that he was not sure how the activities program worked at the facility, but he believed various staff went into the residents ' rooms to talk with the residents. He did not explain who the various staff were. Nurse #2 stated there were no group activities in the dining/common area that he was aware of. Nurse #2 stated he did not bring residents to any activities since COVID-19 started.

An interview was conducted with Nurse Aide (NA) #1 on 07/12/22 at 1:33 PM. NA #1 stated she had been employed with the facility for about 6 years. She stated there used to be an Activities Director at the facility but that was a couple of years ago. NA #1 stated she would try to do 1:1 activities with the residents if she had time such as reading them a book, sitting with the resident, or playing music in their room, whatever interested the resident. NA #1 stated there were not any group activities, but a harp player would sometimes come and play the harp in the dining/common area once a week or so. NA #1

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stated it was difficult to incorporate group activities with the long-term care residents and the rehab residents due to the workload of the aides and the nurses. NA #1 stated Resident #68 was getting therapy and would participate with therapy. NA #1 stated she invited Resident #68 to come out of his room to go to the dining room for his meals, but he would refuse to eat in the dining room and would stay in his room and just do the therapy.

An interview was conducted with Administrator #1 on 07/12/22 at 11:00 AM. Administrator #1 reported there was no designated Activities Director, and the facility utilized the household model whereas everyone participated with the activities program. Administrator #1 stated there were no structured activities and the household was predicated on social interaction either in their rooms or in groups in the dining area/common area; adding, whatever the resident wanted it to be. Administrator #1 stated it was a group effort of all the staff to have residents attend activities. Administrator #1 was made aware that on 07/10/22 and 07/11/22 no activities were observed in the dining area/common area. Administrator #1 stated the facility was going to have to make changes with the household model as it pertained to activities, but she did not share what those changes would be. She added the new Administrator (Administrator #2 who was orienting during this survey) would be conducting the activities this week so that she could use this time to get to know the residents. Administrator #1 added, there had been a lot of agency staff working at the facility and they did not always know the expectation of being responsible for getting the residents involved with activities. During this interview Administrator #1 provided an

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activities calendar for the current week with the following schedule of activities that were to be conducted by Administrator #2:

- Sunday 07/10/22: No activities listed
- Monday 07/11/22: 3:00 PM ice cream social /lunchtime friendly visits
- Tuesday 07/12/22: 11:00 AM Music and Movement - 3:00 PM Trivia
- Wednesday 07/13/22: 11:00 AM Coffee and Current Events - 2:00 PM Bingo
- Thursday 07/14/22: 1:00 PM Manicures - 3:00 PM Community Circle
- Friday 07/15/22: 12:00 PM Self Directed Activity - 3:00 PM Funny movie Friday
- Saturday 07/16/22: No activities listed

An interview was conducted with Administrator #2 on 07/12/22 at 9:30 AM. Administrator #2 revealed on 07/11/22 around 3:00 PM she went around to each of the residents' rooms to introduce herself and brought them an ice cream. She stated it was not a group gathering, she just went to the individual rooms. Administrator #2 stated she had not done any activities prior to today with the residents, but she had personally met with a few of the residents prior to today.

An observation of a group activity directed by Administrator #2 on 07/12/22 at 3:00 PM revealed Resident #68 was sitting within the group of 3 other residents in the common area and participating in a game of trivia.

An observation of a group activity directed by Administrator #2 on 07/13/22 at 2:00 PM revealed Resident #68 was sitting within a group in the dining area while bingo was being played.

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F 680	Continued From page 23	F 680		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observations, and family and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional which resulted in the facility ' s failure to develop, implement, supervise, and provide ongoing evaluation of the activities ' program. This deficient practice had the potential to effect 19 of 19 residents that were residing in the facility. Findings included: Observations on 07/10/22 from 12:00 PM till 6:00 PM revealed there were no structured activities being conducted in the facility.	F 680	F680 1. The designated activity staff member was registered for the Activities professional course on 8/8/2022. 2. The designated activity staff member will receive oversight from another qualified activities professional within the organization for the duration of their certification program. 3. Administrator trained regarding regulation for qualified activity professional on 8/19/22. 4. The CEO/COO or designee will ensure turnover in activities professional position results in appropriate designation	8/19/22

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F 680	Continued From page 24 An interview was conducted with a family member (FM) of Resident #68 on 07/10/22 at 4:45 PM. The FM stated Resident #68 was confused and could not make his needs known at all times. The FM revealed she was concerned that whenever she would come to visit Resident #68 during the day hours or around dinner time, he was always in his room and not participating in any activities. The FM stated she visited daily during the afternoon hours and stayed through dinner, and she had not ever seen any activities occur during her visits. The FM indicated she thought Resident #68 was lonely and needed more stimulation. Observations on 07/11/22 from 8:30 AM through 5:00 PM revealed there were no structured activities being conducted in the facility. An interview was conducted with Nurse #2 on 07/12/22 at 11:10 AM. Nurse #2 stated he had been working at the facility for a couple of years. He stated he was not agency staff. He reported that he was not sure how the activities program worked at the facility, but he believed various staff went into the residents ' rooms to talk with the residents. He did not explain who the various staff were. Nurse #2 stated there were no group activities in the dining/common area that he was aware of. Nurse #2 stated he did not bring residents to any activities since COVID-19 started. An interview was conducted with Nurse Aide (NA) #1 on 07/12/22 at 1:33 PM. NA #1 stated she had been employed with the facility for about 6 years. She stated there used to be an Activities Director at the facility but that was a couple of	F 680	of interim until qualified candidate can be recruited, hired and trained. Any change to the position will be monitored by the QAPI committee.	

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years ago. NA #1 stated she would try to do 1:1 activities with the residents if she had time such as reading them a book, sitting with the resident, or playing music in their room, whatever interested the resident. NA #1 stated there were not any group activities. NA #1 stated it was difficult to incorporate group activities with the long-term care residents and the rehab residents due to the workload of the aides and the nurses.

An interview was conducted with Administrator #1 on 07/12/22 at 11:00 AM. Administrator #1 reported there was no designated Activities Director at the facility. She explained that the facility utilized the household model whereas everyone participated with the activities program and there was not one person who was responsible to direct the provision of activities to the residents. Administrator #1 stated there were no structured activities and the household was predicated on social interaction either in their rooms or in groups; adding, whatever the resident wanted it to be. Administrator #1 stated the facility was going to have to make changes with the household model as it pertained to activities. She did not explain what changes were going to be made.

During a follow up interview via phone with Administrator #1 on 07/26/22 at 1:07 PM she provided conflicting information from her previous interview (07/12/22 at 11:00 AM) reporting the facility previously had a qualified activities professional employed from 10/29/2014 to 05/02/2022. Administrator #1 indicated a new employee was promoted to the Wellness Guide position (the job title the facility utilized for the activities professional position) on 05/26/22, but the new employee had not been enrolled in the

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F 680	Continued From page 26 activities professional class. She explained that staff at the facility were not aware that the activities director position was referred to as a Wellness Guide and not an Activities Director. Administrator #1 stated she believed that was why the staff were saying there was no Activities Director.	F 680		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 761	F761	8/19/22

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F 761	Continued From page 27 facility failed to date 2 of 2 insulin pens that were opened and kept inside the medication storage cabinet in the resident ' s room (Resident #119), discard expired nasal spray for Resident #67, and ensure medication storage cabinets inside of each resident room contained medication ordered for the resident who resided in the room (Resident #67) for 2 of 2 medication cabinets observed. Findings included: a. An observation 07/12/22 at 8:30 AM with Nurse #2 in Resident #119 ' s medication storage cabinet located inside the resident ' s room revealed 2 insulin pens that were opened and not dated. An interview with Nurse #2 on 07/12/22 at 8:30 AM revealed the resident received his insulin early this morning. Nurse #2 stated the insulin pens should have been dated when they were opened because they were only good for 28 days and if there was no date on the insulin pens, nurses would not know when to discard them. Nurse #2 stated all nurses and medication aides were responsible for checking the medication storage cabinets each time they administered medications to ensure medications including insulin pens were dated when they were opened and there were no expired medications in the cabinet. b. An observation on 07/12/22 at 8:55 AM with Nurse #2 in Resident #67 ' s medication storage cabinet located inside the resident ' s room revealed nasal spray that was expired on 02/22/22. It was also noted there were two blister cards of potassium supplement medication in the	F 761	1. The identified insulin pens, expired nasal spray and medication for any other resident was discarded during the on site survey. 2. Other residents medications were audited for dating of open multi dose medication, expired medication and proper resident location with correction as appropriate. 3. Staff was retrained regarding proper dating of insulin pens, removal of expired medication and proper location per resident. upon opening on 7/12/2022. 4. The DON or designee will audit medications for dating of open multi dose medication, expired medication and proper resident location weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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F 761	Continued From page 28 medication storage bin that was for another resident An interview with Nurse #2 on 07/12/22 at 8:55 AM revealed he was not aware the nasal spray had expired, and he had no idea how another resident ' s medication got into Resident #67 ' s cabinet. Nurse #2 stated all nurses and medication aides were responsible for checking the medication storage cabinets each time they administered medications to ensure they had the right patient, right drug, right dose, right route, and right time and to make sure there were no expired medications in the cabinet. An interview with the Director of Nursing (DON) on 07/13/22 stated nursing staff were responsible for labeling the insulin pens with an opened date as soon as it was opened. The DON added, the nursing staff should be checking that insulin pens are dated, there are no expired medications in the cabinet and checking each medication card before they administer the medication to ensure the nurses have the right patient, right drug, right dose, right route, and right time on the medication card.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		8/19/22

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resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.

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(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice

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administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:

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F 849	Continued From page 32 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to coordinate a plan of care with the hospice provider for 1 of 1 resident (Resident #3) reviewed for hospice care. The findings included: Resident #3 was admitted to the facility on 3/7/22 with medical diagnoses which included in part:	F 849	F849 1. The identified care plan was coordinated with hospice and corrected during the on-site survey. 2. Other residents with hospice services were reviewed and care plans corrected as appropriate. 3. Staff was retrained regarding expectation of completion of hospice care	

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F 849	Continued From page 33 open wound to left leg, osteomyelitis, pressure ulcer, chronic obstructive pulmonary disease, and neuropathy (nerve damage). Review of the 3/11/22 Admission Minimum Data Set (MDS) assessment revealed Resident #3 was cognitively intact and hospice care was not indicated. An Election of Hospice benefit was signed by the resident on 3/11/22. Review of the care plan dated 3/24/22 included a nutritional deficit problem which noted that Resident #3 received Hospice services. No other care plan problems indicated that resident received hospice services. A hospice binder, located at the nurse station, included information of all the residents receiving hospice services. The only information regarding Resident #3 contained in the binder was nurse progress notes dated 3/11/22 and 6/9/22. A review of Resident #3's medical record did not reveal a current hospice plan of care or hospice progress notes. An interview was conducted with the MDS Nurse on 7/13/22 at 1:30 PM. She confirmed that Resident #3 had elected the hospice benefit on 3/11/22 and the services were ongoing. The MDS Nurse stated that the facility care plan should contain information regarding the hospice services and interventions provided. The MDS Nurse could not locate any documentation to show that the care plan had been collaborated with the hospice staff. She further indicated that hospice had not participated in care plan	F 849	plan coordination on 7/29/22. 4. The DON or designee will audit to ensure care plans are coordinated with hospice weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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F 849	Continued From page 34 meetings at the facility with the resident, family or facility staff and there was not a current copy of the hospice care plan available for Resident #3. An interview with the Director of Nursing (DON) on 7/13/22 at 1:30 PM revealed that there were no current hospice progress notes or care plan in the hospice binder or Resident #3's medical record. The DON then called the hospice provider and obtained a copy of the care plan dated 6/9/22 which indicated Resident #3 was to receive weekly visits. An interview was conducted with the Administrator on 7/13/22 at 5:55 PM. She indicated it was her expectation that a Hospice care plan was available for all residents receiving hospice services. She further explained that her expectation was coordination of care plans between the facility, resident, family, and hospice would take place.	F 849		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assurance (QA) program failed to maintain implemented procedures and monitor interventions put into place following the recertification and complaint investigation survey of 03/26/21 to prevent the reoccurrence of	F 867	F867 1. The QA process for on-going monitoring of previously cited deficiencies was reviewed and revised. 2. Other QA efforts designed to prevent the reoccurrence of deficient practice will	8/19/22

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F 867	Continued From page 35 deficient practice related to not labeling insulin pens with an open date which resulted in a repeat deficiency on the current recertification survey of 06/13/22 at F761 Label/Store Drugs and Biologicals. The continued failure of the facility during 2 federal surveys showed a pattern of the facility ' s inability to sustain an effective QA program. Findings included: This tag is cross referenced to: F761: Based on observations and staff interviews, the facility failed to date 2 of 2 insulin pens that were opened and kept inside the medication storage cabinet in the resident ' s room (Resident #119), discard expired nasal spray for Resident #67, and ensure medication storage cabinets inside of each resident room contained medication ordered for the resident who resided in the room (Resident #67) for 2 of 2 medication storage cabinets. Review of the facility ' s survey history revealed F761 was cited during the facility ' s 03/26/21 annual recertification and complaint survey for not labeling insulin pens with an open date once opened. The facility was re-cited during the current annual recertification for the same issue of not labeling insulin pens with an opened date. An interview was conducted with the Director of Nursing on 07/13/22 at 8:10 AM. The DON stated the previous plan of correction was for audits was done weekly for 4 weeks and then monthly for 3 months. The DON indicated that a longer period in QA may have allowed the facility to monitor and audit medication storage and to	F 867	be extended as noted in the current plan of correction. 3. Staff was retrained regarding maintaining QA systems and processes on 8/19/22. 4. The Administrator or designee will audit QA follow-up weekly for 8 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months.	

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F 867	Continued From page 36 provide further education to the nurses if needed.	F 867		