STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 7/25-29/2022. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# D8R311	E 000		
F 000	INITIAL COMMENTS A complaint survey was conducted from 7/25/2022 through 7/29/2022. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.45 at tag F760 at a scope and severity (J) The tag F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 3/18/2022 and was removed on 7/29/2022. An partial extended survey was conducted. 7 of the 43 complaint allegations were substantiated resulting in deficiencies. Intakes investigated: NC00188314 NC00189422 NC00189478 NC00190166 NC00190323 NC00191085 NC00191167 NC00191142 NC00191143 NC00191253 NC00191310	F 000		

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

Electronically Signed | 08/16/2022

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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. (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).	F 580		7/29/22

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F 580	Continued From page 2 §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 observation, record review and resident, staff, physician and neurologist interview the facility failed to notify a Resident's Physician when two doses of an anticonvulsant (anti-seizure) medication were not available to administer on 03/18/22. The resident had two episodes of seizure activity and required two hospitalizations to control the seizure activity on 03/19/22-03/21/22 and 03/24/22-03/28/22 for 1 of 3 residents reviewed for medication management (Resident #1). Immediate Jeopardy began on 03/18/22 when the facility failed to administer two doses of an anti-convulsant medication and notify the Physician that the medication was not available. Resident #1 had two episodes of seizure activity and required hospitalization on 03/19/22 and 03/24/22. Immediate Jeopardy was removed on 07/29/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with potential for more that minimal harm that is not immediate jeopardy) to correct the deficient practice and ensure monitoring systems put in place to	F 580	This constitutes a written allegation of compliance. Preparation and submission of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. This allegation of compliance is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. F580 • Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance Resident #1 was discharged from the facility on 3/24/22. Nurse Managers will complete an audit on 7/28/22 of the Medication Administration	

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F 580	Continued From page 3 remove the immediate jeopardy are effective. Findings included: Resident #1 was admitted to the facility on 12/15/21 with diagnoses that included Sialidosis (a hereditary disorder that causes impaired vision and coordination), epilepsy (seizure disorder) and myoclonus (muscle twitching). A physician order for Resident #1 indicated the anti-convulsant medication Brivaracetam tablet 50 milligram (mg) was ordered two times a day for epilepsy (seizure disorder) on 02/11/22. Review of the March Medication Administration Record (MAR) revealed Resident #1 did not receive the two doses on 03/18/22 due to the medication not being available. Record review of the MAR for the Brivaracetam administration for 03/18/22 indicated Nurse #2 failed to give the 8:00 AM dose and Nurse #1 failed to administer the 8:00 PM dose to Resident #1. Review of the Medication Administration Record (MAR) for Resident #1 for the 03/18/22 8:00 AM Brivaracetam dose noted '9-other', and Nurse #2 documented 'waiting on pharmacy delivery.' A phone interview was conducted on 07/27/22 at 4:24 PM with Nurse #2 regarding the 03/18/22 8:00 AM Brivaracetam dose not being administered and physician notification. She did not recall Resident #1 or the missing medication details. Nurse #2 said if she did not have the medication to administer, she would have called the pharmacy to ensure they had the order.	F 580	Records of current residents receiving anti-seizure medications and validate that these medications have been administered during the last 7 days. A Medication error report will be completed by the Nurse Managers for any missing documentation and the Physician notified immediately. • Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete Nurse Managers will re-educate licensed nurses, including agency staff, regarding the facility's policy for notifying the Physician to include notification related to physician ordered anti-seizure medications that are unavailable for administration. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 7/28/22 by the Nurse Managers. The Regional Director of Clinical Services educated the Director of Nursing, Nurse Managers and the Administrator regarding the clinical morning meeting process to include a review of residents receiving anti-seizure medications to validate documentation of notification to the physician related to ordered anti-seizure medications unavailable for administration. This education was	

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F 580	Continued From page 4	F 580		

Nurse #2 added if the pharmacy was sending the medication, she would not have called the doctor. She said she did not recall notifying any Provider. She noted she would only call the doctor if the medication was not on its way or if it needed a new prescription.

Record review of the MAR revealed for the 03/18/22 8:00 PM Brivaracetam dose for Resident #1, Nurse #1 had documented at 10:41 PM on 03/18/22. It noted: "9-other, in route from pharmacy, resident vitals all within normal limits."

A phone interview was conducted on 07/28/22 at 12:08 PM with Nurse #1 that had not administered the Brivaracetam medication on 03/18/22 at 8:00 PM for Resident #1 regarding physician notification. She stated, "the medication was not available, I had checked with pharmacy." She said she was talking "generally as she did not recall the event." Nurse #1 noted the process for notifying would have been to call the on-call physician, and usually she would let the physician know the expected time of arrival. She believed the medicine was an issue. She was 'informed that her medical record note was-'medication in route from pharmacy.' Nurse #1 stated she "would have known to call the physician and she did not know why this documentation was not there, but no one told me to call the physician from the facility and she can't explain why she did not document it."

Record review indicated on 03/19/22 the resident had a seizure lasting 35 minutes. Emergency Medical Services (EMS) were called and administered two doses intravenously (IV) of the sedative Midazolam enroute to the hospital. Resident #1 was hospitalized until 03/21/22.

completed on 7/28/22.

Effective 7/28/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance
Alleged Date of IJ Removal: 7/28/2022

Resident #1 was discharged from the facility on 3/24/2022.

Nurse Managers completed an audit on 7/28/22 of the Medication Administration Records of current residents receiving anti-seizure medications and validate that these medications have been administered during the last 7 days. A Medication error report was be completed by the Nurse Managers for any missing documentation and the Physician notified immediately. Initial audit of residents ordered anti-seizure medications revealed no irregularities and no medication error reports were required as a result of this audit.

The Regional Director of Clinical Services educated the Director of Nursing, Nurse Managers and the Administrator regarding the clinical morning meeting process to include a review of residents receiving anti-seizure medications to validate documentation of administration of medications as ordered by the physician. Education was completed on 7/28/2022.

Licensed nurses, including agency staff were educated regarding the process for obtaining an ordered medication that is

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F 580	Continued From page 5 Review of the MAR indicated Resident #1 received his medications as ordered twice daily upon return from the hospital on 03/21/22 8:00 PM-03/23/22 8:00 PM. Record review noted on 03/24/22, Resident #1 had another seizure for 20 minutes. EMS was called and he received IV Midazolam by EMS and was transported to the hospital. The Neurologist was interviewed via phone on 7/27/22 at 12:46 PM regarding Resident #1. He stated the medication Brivaracetam were being used for his myoclonus(tremors) and the seizures. He stated the nurses needed to be educated on the importance of giving medications as ordered and obtaining the medications. The Physician stated the nurse should have called when the medication was not available. The Neurologist noted if he would have been called, he would have called a local pharmacy if the facility's Pharmacy could not provide it. The Neurologist stated when he did not receive the medications it caused the resident harm and he had breakthrough seizures because of it. A follow up phone interview with the Neurologist was conducted on 07/27/22 at 4:51 PM regarding Resident #1's Brivaracetam doses that were not administered on 03/18/22. He stated when the resident missed the 2 doses of medication, it resulted in seizures due to non-therapeutic blood levels and the second hospitalization was also due to the 2 missing doses. He stated it took a while to get the optimum blood level back and it can take several days to occur. He noted education should be done on the importance of ensuring they had the medication and to call the	F 580	unavailable for administration, including contacting the pharmacy to obtain the medication, notification of the physician, and documentation of such. Education was completed by 7/28/22. Education will continue with newly hired licensed nurses and/or agency staff prior to the start of work. Nurse Managers and/or designee will complete an audit of the medication carts weekly on Thursdays to validate seizure medications are available for administration and needs identified will be corrected. Findings will be documented on the appropriate audit tool. During regularly scheduled clinical meetings on Monday – Friday, Nurse Managers will review Medication Administration Records (MARs) for residents on anti-seizure medications to ensure that anti-seizure medications were available since the day of the previous audit and that anti-seizure medications have been administered as ordered by the physician and that the appropriate measures were taking if medications were unable to be administered as ordered. Beginning on 7/29/2022, audits will be completed five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. The Administrator will review the completed audits on a weekly basis to	

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F 580	Continued From page 6 physician when they don't have the medication, even one dose was crucial. He noted that when Resident #1 did not receive the medication, it led him to have breakthrough seizures and the rehospitalization was also due to him missing the medication, which was also a breakthrough seizure. He stated it can take many days to get the therapeutic/optimum blood level back to regulate the brain and control the seizures when the seizure medications were stopped. He added it was not unusual for it to take 5 days or more for this to occur. The Medical Director was interviewed via phone on 7/27/22 at 1:37 PM regarding the Brivaracetam doses not being administered to Resident #1 for 24 hours. He was informed the resident had seizure activity and resident required hospitalization on 03/19/22 and 03/24/22 following the missed doses. He stated he would have expected the on call physician would be notified when the medication was not available. The Medical Director stated he did not believe it was significant harm that occurred. An interview was done with the Unit Manager (UM) on 07/26/22 at 11:27 AM regarding medication administration. She stated the nurses should have notified the Physician if medications were not given to Resident #1. The Director of Nursing was interviewed on 07/27/22 at 2:30 PM regarding the anti-seizure medication not administered to Resident #1. The DON stated that the Physician should have been notified when the medication was not available, and the nurses had been educated as it was cited recently.	F 580	ensure compliance. The Director of Nursing, Administrator and/or designee will bring results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance. Date of Compliance: 7/29/2022	

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F 580	Continued From page 7	F 580		

The Director of Nursing provided an orientation/education packet on 07/27/22 that was being given to agency nurses currently. Review of the paperwork titled: 'New hire education checklist, for complaint survey 8/18/21-8/31/21' and 'F580-notification of changes' was done. It noted:
-report to the medical provider/on call medical provider medications that are unavailable to be administered as ordered.
-Notification to provider and response/received orders must be documented in the resident's medical record.

A phone interview was conducted with the Administrator on 07/28/22 at 9:09 AM regarding Resident #1 not receiving his Brivaracetam medication. He stated that medication should be available, given as ordered and the physician should be notified if the medication was not available.

The Administrator was informed of Immediate Jeopardy (IJ) on 07/28/22 at 10:07 AM.

The Facility provided the following Credible Allegation of IJ removal.

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

Resident#1 did not receive physician ordered anti-seizure medications on 3/18/22 due to the medication not being available from the pharmacy. The Medical Director was not notified the medication was unavailable to be administered as ordered. Resident #1 had seizure activity on 3/19/22 and was found in bed

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having seizures. The resident was assessed and 911 transported the resident to Emergency Room. As paramedics were transferring resident from bed to stretcher, he had another seizure. Resident #1 was admitted to the hospital and readmitted to the facility on 3/21/22. He returned to the hospital on 3/24/22 for seizure activity and did not return to the facility.

Nurse Managers will complete an audit on 7/28/22 of the Medication Administration Records of current residents with physician ordered anti-seizure medications and identify those who did not receive anti-seizure medications as ordered during the last 7 days. A Medication error report will be completed by the Nurse Managers for any missing documentation and the Physician notified immediately.

- Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Nurse Managers will re-educate licensed nurses, including agency staff, regarding the facility's policy for notifying the Physician to include notification related to physician ordered anti-seizure medications that are unavailable for administration. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 7/28/22 by the Nurse Managers.

The Regional Director of Clinical Services educated the Director of Nursing, Nurse Managers and the Administrator regarding the

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F 580	Continued From page 9 clinical morning meeting process to include a review of the Medication Administration Report for residents with physician ordered anti-seizure medications to identify those who did not receive anti-seizure medications as ordered and validate documentation of notification to the physician related to ordered anti-seizure medications unavailable for administration. This education was completed on 07/28/22. Effective 07/28/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance Alleged Date of IJ Removal: 07/29/2022 The credible allegation of Immediate Jeopardy was validated on 07/29/22 as evidenced by onsite validation through record review, observations and staff interviews. Staff were interviewed to validate in-service education completion and education rosters were reviewed. The Immediate Jeopardy was removed on 07/29/22.	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, 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	F 584		8/15/22

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F 584	Continued From page 10 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: Based on observations and staff interviews the facility failed to provide linen in good and clean condition in 1 of 1 clean linen closet, 1 of 4 clean linen carts and the laundry room reviewed for safe, clean, comfortable, homelike environment. Findings included:	F 584	No residents were found to have been affected. All residents have the potential to be affected. On 8/1/2022, the Environmental Services	

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F 584	Continued From page 11 1.a An observation with the Laundry Director on 07/25/22 at 1:31 PM revealed clean linen was being placed in the central clean linen closet 100 hall. Further observation revealed 3 of 7 flat sheets with multiple black strains of hair, 3 of 10 blankets with large visible yellow stains, 3 of 10 towels with large visible brown stains, and 5 of 10 wash cloths with visible yellow and brown stains. An interview conducted on 7/25/22 at 1:36 PM with the Laundry Director revealed the bath blankets were used underneath residents to keep the bed from being soiled. She further stated the blankets do not go over the top of the residents' beds. She stated the stained linen was only used for wiping up spills on the floor and washing the residents' hands. She further revealed the linen was checked daily for cleanliness or stains. She stated she would pull the stained or unclean linen, and this must have been an oversight. b. An observation of D-Hall linen cart on 7/25/22 at 1:38 PM revealed 2 of 2 fitted sheets with large visible streaked brown stains. An interview conducted with the Laundry Director 7/25/22 at 1:40 PM revealed the fitted sheets should have been discarded and not available for use. She further revealed it must have been an oversight on her part as she worked in laundry over the weekend. c. An observation with Laundry Aid #1 and Laundry Aid #2 on 7/26/22 at 12:35 PM revealed clean linen was being place on the shelf in the clean line storage area. Further observation revealed 8 of 10 fitted sheets with holes and large	F 584	Manager completed an audit of circulating linen and took out of circulation linens that were not in good and clean condition. At this time, a linen order was placed, and linens taken out of circulation were replaced with linens in good and clean condition. The Regional Director of Environmental Services, Administrator, and/or designee will educate environmental services staff regarding providing linen in good and clean condition for resident use, including taking out of circulation linens that are ripped, stained, and/or not in good condition. This education will be completed on or before Monday 8/15/2022. Education will continue with newly hired environmental services staff, including agency staff, prior to the start of work. The Director of Nursing, Administrator, Nurse Managers and/or designee will educate direct care staff regarding providing linen in good and clean condition for resident use, including taking out of circulation linens that are ripped, stained, and/or not in good condition. This education will be completed on or before Monday 8/15/2022. Education will continue with newly hired direct care staff, including agency staff, prior to the start of work. The Environmental Services Manager and/or designee will complete an audit of the clean linen room and linen carts to	

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F 584	Continued From page 12 brown and yellow visible stains, 4 of 8 wash cloths with brown and black visible stains, 2 of 6 flat sheets with large brown stains and long brown hair, and 3 of 7 towels with visible brownish black large stains. An interview conducted with Laundry Aide #1 and Laundry Aide #2 on 7/26/22 at 12:35 PM revealed the lighting was not good in the laundry area and this was how the stained linen was missed. They revealed the stains had to be very large before they would discard the linen. Laundry Aide #1 and Laundry Aide #2 stated they checked for stains during the folding process, but they did not check it again before it was placed on the shelf. The Laundry Aides further revealed the linen should have been discarded or rewashed. An interview with the Administrator on 7/26/22 at 12:40 PM revealed the linen should be clean and in good repair. He further revealed the linen should not have any stains or tears. He stated it was the Laundry Director's responsibility to make sure the linen was checked and not put on the shelf for resident use.	F 584	ensure that linen provided for resident use is in good and clean condition. Any identified areas of concern will be corrected immediately. Beginning on 8/15/2022, the Environmental Services Manager and/or designee will complete an audit of the clean linen room and linen carts to ensure that linen provided for resident use is in good and clean condition. Any identified areas of concern will be corrected immediately. Audits will be completed five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. The Administrator will review the completed audits on a weekly basis to ensure compliance. The Environmental Services Manager, Administrator and/or designee will bring results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance.	
F 760 SS=J	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	F 760		7/29/22

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by:
Based on observations, record review and resident, staff, physician and neurologist interviews, the facility failed to administer two doses of an anticonvulsant (anti-seizure) medication, the resident had two episodes of seizure activity and required two hospitalizations to control the seizures (03/19/22-03/21/22 and 03/24/22-03/28/22) for 1 of 3 resident reviewed for significant medications (Resident #1).

Immediate Jeopardy began on 03/18/22 when the facility failed to administer two doses of an anti-convulsant medication. Resident #1 had two episodes of seizure activity and required hospitalization on 03/19/22 and 03/24/22. Immediate Jeopardy was removed on 07/29/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to correct the deficient practice and ensure monitoring systems put in place to remove the immediate jeopardy are effective.

Findings included:

Resident #1 was admitted to the facility on 12/15/21 with diagnoses that included Sialidosis (a hereditary disorder that causes impaired vision and coordination), epilepsy (seizure disorder) and myoclonus (muscle twitching).

A physician order for Resident #1 indicated the anti-convulsant medication Brivaracetam 50 milligram (mg) tablet was ordered two times a day for epilepsy (seizure disorder) on 02/11/22.

Resident #1 was discharged from the facility on 3/24/2022.

On 7/28/2022, Nurse Managers completed an audit of current residents receiving anti-seizure medications, validated that these medications are available for administration. Findings of this audit revealed no further incidences of anti-seizure medications not being available for administration as ordered.

The Regional Director of Clinical Services educated the Director of Nursing, Nurse Managers and the Administrator regarding the clinical morning meeting process to include a review of residents receiving anti-seizure medications to validate documentation of administration of medications as ordered by the physician. Education was completed on 7/28/2022.

Licensed nurses, including agency staff were educated regarding the process for obtaining an ordered medication that is unavailable for administration, including contacting the pharmacy to obtain the medication, notification of the physician, and documentation of such. Education was completed by 7/28/22. Education will continue with newly hired licensed nurses and/or agency staff prior to the start of work by the Director of Nursing, Nurse Managers, and/or designee.

Nurse Managers and/or designee will complete an audit of the medication carts weekly on Thursdays to validate seizure

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F 760	Continued From page 14 Review of the March Medication Administration Record (MAR) revealed Resident #1 did not receive the two doses on 03/18/22 due to the medication not being available. On 07/27/22, the Director of Nursing obtained the Pharmacy delivery slips that indicated the Medication Brivaracetam was ordered from pharmacy on 03/17/22 and delivered late on 3/18/22 for Resident #1. A nurse had dated and signed for the medication, but no time was noted in the date field on the form. Record review of the MAR for the Brivaracetam medication on 03/28/22 indicated Nurse #2 failed to give the medication at 8:00 AM and Nurse #1 did not administer the 8:00 PM dose to Resident #1. Review of the Medication Administration Record (MAR) for Resident #1 for the 03/18/22 8:00 AM Brivaracetam dose noted '9-other', and Nurse #2 documented 'waiting on pharmacy delivery.' A phone interview was conducted on 07/27/22 at 4:24 PM with Nurse #2 regarding the 03/18/22 8:00 AM Brivaracetam dose not being administered. She did not recall the resident or the missing medication details for Resident #1. Record review of the MAR revealed for the 03/18/22 8:00 PM Brivaracetam dose for Resident #1, Nurse #1 had documented at 10:41 PM on 03/18/22. It noted: "9-other, in route from pharmacy, resident vitals all within normal limits." A phone interview was conducted on 07/28/22 at 12:08 PM with Nurse #1 that had not	F 760	medications are available for administration and needs identified will be corrected. Findings will be documented on the appropriate audit tool. During regularly scheduled clinical meetings on Monday - Friday, Nurse Managers will review Medication Administration Records (MARs) for residents on anti-seizure medications to ensure that anti-seizure medications were available since the day of the previous audit and that anti-seizure medications have been administered as ordered by the physician. Beginning on 7/29/2022, audits will be completed five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. The Administrator will review the completed audits on a weekly basis to ensure compliance. The Director of Nursing, Administrator and/or designee will bring results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance. Date of Compliance: 7/29/2022	

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administered the Brivaracetam medication on 03/18/22 at 8:00 PM for Resident #1. She stated, "the medication was not available, I had checked with pharmacy."

Record review indicated on 03/19/22 the resident had a seizure lasting 35 minutes. Emergency Medical Services (EMS) were called and administered two doses intravenously (IV) of the sedative Midazolam enroute to the hospital. Resident #1 was hospitalized until 03/21/22.

Review of the MAR indicated Resident #1 received his medications as ordered twice daily upon return from the hospital on 03/21/22 8:00 PM-03/23/22 8:00 PM.

Record review noted on 03/24/22, Resident #1 had another seizure for 20 minutes. EMS was called and he received IV Midazolam by EMS and was transported to the hospital.

The Minimum Data Set (MDS) Assessment completed on 03/24/22 indicated Resident #1 was cognitively intact.

Review of the hospital records indicated Resident #1 was discharged from the hospital to another facility on 03/28/22.

The Director of Nursing was interviewed on 07/27/22 at 2:30 PM regarding the anti-seizure medication for Resident #1. She stated if the medication was not there, the nurse should have checked the automated drug dispensing machine, called the pharmacy to see if the medication was on the way and notified the physician if the medication was not available.

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The Neurologist was interviewed via phone on 07/27/22 at 12:46 PM regarding Resident #1. He stated the medication Brivaracetam were being used for his myoclonus (muscle twitching) and the seizures. He stated the nurses needed to be educated on the importance of giving medications as ordered and getting the medications. The Physician stated the nurse should have called when the medication was not available. The Neurologist stated when he did not receive the medications it caused the resident harm and he had breakthrough seizures because of it.

A follow up phone interview with the Neurologist was conducted on 07/27/22 at 4:51 PM regarding Resident #1's Brivaracetam doses, that were not administered on 03/18/22. He stated when the resident missed the 2 doses of medication, it resulted in seizures due to non-therapeutic blood levels and the second hospitalization was also due to the 2 missing doses. He noted that when Resident #1 did not receive the medication, it led him to have breakthrough seizures and the rehospitalization was also due to him missing the medication, which was also a breakthrough seizure. He stated it can take many days to get the therapeutic/optimum blood level back to regulate the brain and control the seizures when the seizure medications were stopped. He added it was not unusual for it to take 5 days or more for this to occur.

The Medical Director was interviewed via phone on 07/27/22 at 1:37 PM regarding the Brivaracetam doses not being administered to Resident #1 for 24 hours on 03/18/22. He was informed the resident had seizure activity on 03/19/22 and 03/24/22 and resident required hospitalization both times, following the missed

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doses. He stated he would have expected the on call physician would be notified when the medication was not available. The Medical Director stated he did not believe it was significant harm that occurred.

A follow-up call was received from the Medical Director on 07/28/22 at 12:47 PM. He stated he had reviewed the records for Resident #1 and the neurologist information and the Brivaracetam was being used for tremors not the seizures. He said he thought the second anticonvulsant Resident #1 was on, was being used for seizures. The MAR indicated Brivaracetam was being used for epilepsy (seizures disorder) and he stated it also could be used for other things.

A phone interview was conducted with the Administrator on 07/28/22 at 9:09 AM regarding Resident #1 not receiving his Brivaracetam medication. He stated that medication should be available and given as ordered by the physician and the medication should have been ordered in time to have the doses available.

The Administrator was informed of Immediate Jeopardy (IJ) on 07/28/22 at 10:07 AM.

The Facility provided the following Credible Allegation of IJ removal 7/29/22.

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident#1 did not receive physician ordered anti-seizure medications on 3/18/22 due to the medication not being available from the

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pharmacy. Resident #1 had seizure activity on 3/19/22 and was found in bed having seizures. The resident was assessed and 911 transported the resident to Emergency Room. As paramedics were transferring resident from bed to stretcher, he had another seizure. Resident #1 was admitted to the hospital and readmitted to the facility on 3/21/22. He returned to the hospital on 3/24/22 for seizure activity and did not return to the facility.

Nurse Managers will complete an audit on 7/28/22 of the Medication Administration Records of current residents with physician ordered anti-seizure medications and identify those who did not receive anti-seizure medications as ordered during the last 7 days. A Medication error report will be completed by the Nurse Managers for any missing documentation and the Physician notified immediately.

-Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete,

Nurse Managers will re-educate licensed nurses, including agency staff regarding the process for reordering physician ordered medications and obtaining an ordered medication that is unavailable for administration. This process includes contacting the pharmacy to obtain the medication and notification of the physician when unavailable. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 7/28/22 by the Nurse Managers.

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F 760	Continued From page 19 The Regional Director of Clinical Services educated the Director of Nursing, Nurse Managers and the Administrator regarding the clinical morning meeting process to include a review of the Medication Administration Report for residents with physician ordered anti-seizure medications to identify those who did not receive anti-seizure medications as ordered and validate documentation of notification to the physician related to ordered anti-seizure medications unavailable for administration. The Nurse Managers will complete an audit of the medication carts daily to validate seizure medications are available for administration and needs identified will be corrected. This education was completed on 7/28/22. Effective 07/28/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 07/29/2022 Date of IJ removal 07/29/22 The credible allegation of Immediate Jeopardy was validated on 07/29/22 as evidenced by onsite validation through record review, observations and staff interviews. Staff were interviewed to validate in-service education completion and education rosters were reviewed. The Immediate Jeopardy was removed on 07/29/22.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/15/22

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F 812	Continued From page 20 §483.60(i) Food safety requirements. The facility must - §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, staff interviews and record review, the facility failed to perform hand hygiene for 1 of 3 dietary staff (Dietary Aide #1), monitor refrigerator temperatures for 1 of 1 reach-in refrigerators, store potentially hazardous cold foods at least 41 degrees Fahrenheit (milk, pimento cheese sandwiches and a bologna sandwich), and store pans (muffin pans, sheet pans) and a cutting board clean. This deficient practice had the potential to affect food served to residents. The facility census was 80 residents. The findings included: A. On 7/25/22 at 12:12 PM, Dietary Aide (DA) #1 was observed to open the kitchen door with her bare hands, entered the kitchen, walked to the	F 812	No residents were found to have been affected. All residents residing at the facility have the potential to be affected. On 7/27/2022, the Food Services Manager disposed of items stored at potentially hazardous temperatures and cleaned the bottom drawer of the oven being used as well as the items being stored within the drawer. On 8/1/2022, the Regional Director of Food Services educated the Food Services Manager regarding hand	

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lunch meal tray line in progress, picked up a box of gloves, removed 2 gloves, donned gloves and assisted on the tray line. The box of gloves was visibly soiled. DA #1 did not perform hand hygiene prior to donning gloves and assisting with tray line.

An interview with DA #1 occurred on 7/25/22 at 12:13 PM. DA #1 stated in interview that she left the kitchen earlier to go to the bathroom and while she was in the bathroom, she washed her hands. DA #1 stated she was aware and trained to wash her hands upon each entry to the kitchen, she stated "I knew to do that." She stated that she did not notice that the box of gloves was soiled.

The Dietary Manager (DM) stated in interview on 7/25/22 at 1:22 PM that staff were trained to perform hand hygiene each time they entered the kitchen, and she expected all staff to wash their hands prior to assisting on the tray line.

The Administrator stated on 7/28/22 at 11:30 AM that he expected all dietary staff to wash their hands upon entry to the kitchen.

B. An observation of the reach-in refrigerator occurred on 7/25/22 at 12:35 PM by Cook #1 and the surveyor. A thermometer was not observed in the reach-in refrigerator and there was no record of temperature monitoring. Temperature monitoring at the time of the observation, revealed the following potentially hazardous foods were stored 53.8 degrees Fahrenheit (F) to 55 degrees F:

· An 8-ounce carton of whole milk, and an 8-ounce carton of 2% milk, 53.8 degrees F

hygiene, monitoring of refrigerator temperatures, storing of potentially hazardous cold foods, and storing items clean.

The Food Services Manager will educate cooks and dietary aides regarding hand hygiene, monitoring of refrigerator temperatures, storing of potentially hazardous cold foods, and storing items clean. Education will be completed on/before Monday 8/15/2022. Education will continue with newly hired food services staff, including agency staff, prior to the start of work.

The Food Services Manager and/or designee will complete an audit of the hand hygiene in the kitchen, ensuring that staff is performing hand hygiene per policy. Any identified areas of concern will be corrected immediately, and the staff member re-educated.
Audits will be completed five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool.
The Food Services Manager and/or designee will complete an audit of the refrigerator temperature in the reach in refrigerator to ensure that potentially hazardous food is stored at appropriate temperatures and record findings per policy. Any identified areas of concern will

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F 812	Continued From page 22 · 3 sandwiches (2 pimento cheese and 1 bologna), 55 degrees F Cook #1 was interviewed on 7/25/22 at 12:36 PM and stated that she just looked in the reach-in refrigerator and could not locate a thermometer. Cook #1 further stated that when she worked on 7/20/22, she checked the reach-in refrigerator temperature and there was a thermometer there then, but that she had not checked the reach-in refrigerator temperature since 7/20/22, and when she just looked, she could not locate a thermometer now. The temperature she observed on 7/20/22 she stated was less than 41 degrees F. An interview with DA #1 occurred on 7/25/22 at 12:37 PM and revealed that when she worked the week prior, she did not check the reach-in refrigerator temperature and she could not recall if she observed a thermometer in the reach-in refrigerator when she worked last week. An interview with DA #2 occurred on 7/25/22 at 12:38 PM and revealed she remembered that she checked the reach-in refrigerator temperature one day last week, but she did not recall which day or what the temperature was when she checked. DA #2 stated she had not checked the reach-in refrigerator temperature since last week. An interview with the DM on 7/25/22 at 12:40 PM revealed the dietary department was currently in a temporary kitchen and had been since 7/8/22. The DM stated since the dietary department moved to a temporary kitchen on 7/8/22, she had not yet set up a system for monitoring the temperature of the reach-in refrigerator with a thermometer or temperature log for dietary staff	F 812	be corrected immediately and affected items will be immediately discarded. Audits will be completed five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. The Food Services Manager and/or designee will complete an audit of items stored to ensure that items are stored clean. Any identified areas of concern will be corrected immediately. Audits will be completed five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. The Administrator will review the completed audits on a weekly basis to ensure compliance. The Food Services Manager, Administrator and/or designee will bring results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance.	

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	345130	A. BUILDING _____ B. WING _____	C 07/29/2022

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F 812	Continued From page 23 to record refrigeration temperatures. The DM stated she would get a thermometer immediately and post a log for dietary staff to record refrigeration temperatures. An interview with the Administrator on 7/28/22 at 11:30 AM revealed dietary staff later located a thermometer in the reach-in refrigerator that had fallen and got lodged behind a container. He stated that he expected dietary staff to monitor refrigeration temperatures and maintain cold foods 41 degrees F or below. C. An observation of the storage drawer of the stove occurred on 7/26/22 at 1:00 PM and revealed dried French Fries and food debris on top of muffin pans, sheet pans and a cutting board which were stored ready for use and visibly soiled with dust particles and grease residue. An interview with the DM on 7/26/22 at 1:01 PM revealed the dietary department was currently in a temporary kitchen and had been since 7/8/22. The DM stated she had not opened this storage drawer and did not know these items were stored soiled in a drawer with dried food debris. The DM stated ready to use dishes should be stored clean, and on a clean surface to prevent pest activity. The Administrator stated in an interview on 7/28/22 at 11:30 AM that he expected dietary staff to store dishes clean and ready for use.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a	F 838		8/12/22

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F 838	Continued From page 24	F 838		

facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy,

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F 838	Continued From page 25 pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to review and annually update the facility assessment regarding changes to administrative personnel and resources needed to provide day to day care of the current resident population. Findings included: The facility assessment dated 3/18/2021 was reviewed. The former Administrator was listed as the current administrator. The former Director of Nursing (DON) was listed as the current DON, the former Rehab Director was listed as the current Rehab Director, the former Dietary Manager was listed as the current Dietary Manager, and the former Maintenance Director was listed as the current Maintenance Director.	F 838	No residents were found to have been affected. All residents residing at the facility have the potential to be affected. The Facility Assessment will be updated by the Administrator and/or Director of Nursing on/before Thursday 8/11/2022. The Facility Assessment will be reviewed with the Interdisciplinary Team (IDT) during an Ad-Hoc QAPI Meeting on Friday 8/12/2022. The Facility Assessment will be reviewed with the IDT during routinely held monthly QAPI Meetings and necessary changes will be made at that time. Findings and necessary changes will be recorded in the	

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F 838	Continued From page 26 Further review of the facility assessment revealed the information regarding the special needs of residents did not match the current resident population. The CMS 672 report (a report that provides the resident census and conditions of residents based on the results of the Minimum Data Set assessments) dated 7/25/2022 was reviewed. The CMS 672 documented 4 residents received Hospice care and the facility assessment documented 2 residents received Hospice care. The CMS 672 documented no residents required ostomy care and the facility assessment documented 1 resident required ostomy care. The CMS 672 documented 6 residents required behavioral health and the facility assessment documented 28 residents required behavioral health. The CMS 672 documented 2 residents received dialysis care and the facility report documented no residents received dialysis care. The CMS 672 documented 33 residents required injections and the facility assessment documented 19 residents required injections. An interview with the current DON was conducted 7/27/2022 at 10:53 AM. DON reported the former Administrator had left the facility on 6/30/2022 and she took some documents with her. The DON reported she had reached out to the former Administrator and requested the updated facility assessment, and the former Administrator had emailed the copy of the facility assessment that had been updated on 3/18/2021. The DON reported she remembered assisting the former Administrator with updating the facility assessment but did not know where it was located. The current Administrator was interviewed on	F 838	monthly QAPI Meeting minutes. The Facility Assessment will be reviewed with the IDT during routinely held monthly QAPI Meetings and necessary changes will be made at that time. Findings and necessary changes will be recorded in the monthly QAPI Meeting minutes. Review and updating of the Facility Assessment will take place one (1) time each month for a period of four (4) months, then every other month for a period of four (4) months, then quarterly until 100% compliance is achieved and maintained. The Administrator and/or designee will facilitate review of the Facility Assessment during QAPI Meetings for discussion with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance.	

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F 838	Continued From page 27 7/29/2022 at 4:30 PM. The Administrator reported he had searched for the electronic file of the updated facility assessment, but he had been unable to find it. The Administrator reported the facility assessment should be updated as needed and at least annually to reflect the current administrative personnel as well as the needs of the current resident population. The Administrator reported he would update the facility assessment.	F 838		
F 867 SS=F	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 record reviews. observation and staff and physician interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place in February 2022. This was for 2 re-cited deficiencies which were originally cited on 2/14/2022 during the recertification survey, and on the current complaint investigation survey on 07/29/2022. The recited deficiencies were a failure to notify of changes (F-580) and a failure to prepare and serve food in accordance with professional standards for food service safety (F-812). The continued failure of the facility during the two Federal surveys of record demonstrated a pattern of the facility's inability to sustain an effective Quality Assurance and Performance	F 867	The affected residents have been discharged from the facility. All residents residing at the facility have the potential to be affected. The Administrator, Director of Nursing, and/or designee will educate members of the Interdisciplinary Team (IDT) on the QAPI Process and information to bring to the QAPI Meeting each month relevant to their department. Education will be complete on or before Friday 8/12/2022. Education will continue with newly hired department heads/members of the IDT as appropriate. Nurse Managers completed an audit on	8/15/22

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F 867	Continued From page 28 Improvement Program. The findings included: This tag is cross referred to: 1.a. F-580 Based on observation, record review and resident, staff, physician and neurologist interview the facility failed to notify a Resident's Physician when two doses of an anti-convulsant (anti-seizure) medication were not available to administer on 03/18/22. This resulted in two episodes of seizure activity and hospitalization 03/19/2203/21/22 and 03/24/22-03/28/22 for 1 of 1 resident reviewed for medication management. 1.b. During the facility's recertification and complaint investigation of 02/14/2022 F-580 was cited for failure to notify a Resident's Physician when two different blood pressure medications were not available for administration on 07/21/21 and 07/22/21; and when the blood pressure reading was out of normal range for 1 of 3 residents reviewed for medication management. 1.c. During the facility's complaint investigation of 08/31/2021 F-580 was cited for failure to notify the provider of skin assessment changes for 1 of 3 residents reviewed for pressure ulcers. An interview was conducted with the Director of Nursing (DON) on 07/27/22 at 5:10 PM regarding notification of physician. She stated that audits for the F580 tag from their 02/14/22 recertification survey were still being done when the incident with Resident #1 occurred on 3/18/22. Review of the orientation paperwork provided by the DON that she stated was given to new hires and agency nurses titled: 'new hire education	F 867	7/28/22 of the Medication Administration Records of current residents receiving anti-seizure medications and validate that these medications have been administered during the last 7 days. A Medication error report was be completed by the Nurse Managers for any missing documentation and the Physician notified immediately. Initial audit of residents ordered anti-seizure medications revealed no irregularities and no medication error reports were required as a result of this audit. The Regional Director of Clinical Services educated the Director of Nursing, Nurse Managers and the Administrator regarding the clinical morning meeting process to include a review of residents receiving anti-seizure medications to validate documentation of administration of medications as ordered by the physician. Education was completed on 7/28/2022. Licensed nurses, including agency staff were educated regarding the process for obtaining an ordered medication that is unavailable for administration, including contacting the pharmacy to obtain the medication, notification of the physician, and documentation of such. Education was completed by 7/28/22. Education will continue with newly hired licensed nurses and/or agency staff prior to the start of work. Education will continue with newly hired licensed nurses and/or agency staff during the initial orientation process facilitated by the Director of Nursing, Nurse Managers, and/or designee.	

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F 867	Continued From page 29 checklist'-for complaint survey 8/18/21-8/31/21" included information on F580-notification of changes as noted: -report to the medical provider/on call medical provider medications that are unavailable to be administered as ordered. Notification to provider and response/received orders must be documented in the resident's medical record. The DON reviewed her files and stated an incident report was completed for Resident #1's seizure on 03/19/22 but there was no medication error report completed, although the error was identified in the audits. An interview was done on 07/29/22 at 3:47 PM with the Unit Manager (UM) regarding the QAPI (Quality Assessment Process Improvement) meetings. The UM stated she attended QAPI meetings when she could but had not for the last several times. She was asked if discussion occurred about notification of physicians as needed when medications were not given. She stated it has been several months since she attended in 1st quarter of 2022 and did not recall that being discussed. The UM was asked if she had identified concerns with notification of the physician regarding medications not being available or missing doses and she said no. The Director of Nursing (DON) was interviewed via phone on 07/29/22 at 5:16PM regarding the facility's Quality Assurance Process Improvement (QAPI) process for medications. She stated that in the current QAPI meetings, F580 medication notification to the Provider and medication errors were the only thing discussed. She was asked why there were ongoing issues and the DON said she thought it was agency nurses. She noted they	F 867	On 7/27/2022, the Food Services Manager disposed of items stored at potentially hazardous temperatures and cleaned the bottom drawer of the oven being used as well as the items being stored within the drawer. On 8/1/2022, the Regional Director of Food Services educated the Food Services Manager regarding hand hygiene, monitoring of refrigerator temperatures, storing of potentially hazardous cold foods, and storing items clean. The Food Services Manager will educate cooks and dietary aides regarding hand hygiene, monitoring of refrigerator temperatures, storing of potentially hazardous cold foods, and storing items clean. Education will be completed on/before Monday 8/15/2022. Education will continue with newly hired food services staff, including agency staff, prior to the start of work. Education will be completed with newly hired food services staff, including agency staff, prior to the start of work by the Food Services Manager and/or designee. The Food Services Manager and/or designee will complete an audit of the hand hygiene in the kitchen, ensuring that staff is performing hand hygiene per policy. Any identified areas of concern will be corrected immediately, and the staff member re-educated.	

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F 867	Continued From page 30 try and book the same nurses for 8-12 weeks when they can, but often this was not possible. She said there needed to be more ongoing education with the agency nurses as they came and left frequently. The DON was asked if the agency nurse orientation was adequate, and she said there were things that they could add such as competencies. She noted they expected the agency nurses to be competent but that had shifted in the last couple months, and they need to do an in-house full nurse orientation and have consistent staff. She noted medication ordering needed to be included as well. She noted per the policy that was provided to her on 07/28/22 they are to reorder with 6 doses left. She added she was not familiar with the policy and would be educating staff. An interview was conducted with the Administrator on 07/29/22 at 5:30 PM. He said that had been at the facility since 07/01/22. He stated he had not been to a QAPI meeting but had reviewed the QAPI information from May 2022. He said in the May 2022 meeting, the recertification survey information from 02/14/22 was reviewed. The QAPI committee had discussed the F580 tag and were reviewing the audits. The Administrator said he was unable to determine the root cause of medication reordering issues without participating in the QAPI meeting. He stated anyone that was considered agency staff were to receive a packet of information. 2.a. F-812 Based on observations, staff interviews and record review, the facility failed to perform hand hygiene for 1 of 3 dietary staff (Dietary Aide #1), monitor refrigerator temperatures for 1 of 1 reach-in refrigerators,	F 867	The Food Services Manager and/or designee will complete an audit of the refrigerator temperature in the reach in refrigerator to ensure that potentially hazardous food is stored at appropriate temperatures and record findings per policy. Any identified areas of concern will be corrected immediately and affected items will be immediately discarded. The Food Services Manager and/or designee will complete an audit of items stored to ensure that items are stored clean. Any identified areas of concern will be corrected immediately. Nurse Managers and/or designee will complete an audit of the medication carts weekly on Thursdays for a period of 12 weeks to validate seizure medications are available for administration and needs identified will be corrected. Findings will be documented on the appropriate audit tool. During regularly scheduled clinical meetings on Monday – Friday, Nurse Managers will review Medication Administration Records (MARs) for residents on anti-seizure medications to ensure that anti-seizure medications were available since the day of the previous audit and that anti-seizure medications have been administered as ordered by the physician and that the appropriate measures were taking if medications were unable to be administered as ordered. Audits will be completed by Nurse	

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F 867	Continued From page 31 store potentially hazardous cold foods at least 41 degrees Fahrenheit (milk, pimento cheese sandwiches and a bologna sandwich), and store pans (muffin pans, sheet pans) and a cutting board clean. This deficient practice had the potential to affect food served to residents 2.b. During the facility's recertification and complaint investigation of 2/14/2022 F-812 was cited for failure to 1) thaw a potentially hazardous food with an effective food safety system, and 2) store cold/frozen foods sealed and with a label and date of opening. The facility thawed frozen diced ham, that was not submerged, under running water with a temperature of 93.4 degrees Fahrenheit (F). The facility stored hot dogs, sliced ham, sliced turkey, French fries, pancakes, sliced cheese and chicken tenders without a label and date of opening and open to air. This failure occurred in 2 of 3 cold storage units and had the potential to affect food served to residents. An interview was conducted with the Administrator on 07/29/22 at 4:30 PM. He said that had been at the facility since 07/01/22. He stated he had not been to a QAPI meeting but had reviewed the QAPI information from May 2022. He said in the May 2022 meeting, the recertification survey information from 02/14/22 was reviewed. The Administrator noted he couldn't speculate why the issues continued because he had not participated in a QAPI meeting.	F 867	Managers and/or designee five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. Audits will be completed by the Food Services Manager and/or designee five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. Findings will be documented on the appropriate audit tool. The Administrator will review the completed audits on a weekly basis to ensure compliance. The Food Services Manager, Administrator and/or designee and Nurse Managers and/or designee will bring results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance. The IDT will hold monthly QAPI Meetings on the pre-determined date.	

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F 867	Continued From page 32	F 867	Each member of the IDT will come to the monthly QAPI Meeting prepared to discuss information pertinent to their department. The QAPI Coordinator and/or designee will maintain the monthly QAPI Meeting Minutes. The QAPI Coordinator and/or designee will provide monthly QAPI meeting minutes to the Administrator and Director of Nursing within 3 business days of the QAPI Meeting being held for review. The Administrator and/or designee will review the QAPI Meeting minutes and implement new Performance Improvement Plans (PIPs) with the appropriate member of the IDT as indicated. The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance. Completion Date: 8/15/2022	