STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/28/22 through 12/01/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # BKPG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/28/22 through 12/01/22. The following intakes were investigated NC00195074, NC00195076, NC00194768, NC00194521, NC00194412, NC00194197, NC00104114, NC00193389, NC00192592, NC00189705, and NC00187933. 4 of the 38 complaint allegation were substantiated resulting in deficiencies. Event ID# BKPG11.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		12/26/22

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

Electronically Signed | 12/23/2022

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F 600	Continued From page 1 Based on record review, staff interviews and family interview the facility failed to ensure that a resident was free from neglect when it failed to provide the care after requested for 1 of 1 sampled resident (Resident #64) who required extensive assistance and had an episode of vomiting and incontinence. The reasonable person concept was applied to this deficiency. Individuals would expect to receive the care needed and would be upset wearing a shirt soiled with vomit and wearing a soiled brief after requesting assistance. The findings included: Resident #64 was admitted to the facility on 10/4/22 and readmitted on 11/11/22 with diagnoses that included, stroke, hemiplegia and hemiparesis, left hip fracture, obstructive reflux uropathy, dysphasia, aphasia, Parkinson's, dementia, and unspecified psychosis. The most recent minimum data set for Resident #64 dated 11/18/22 revealed he was cognitively impaired with no behaviors or rejection of care. He required extensive two person assist with bed mobility, dressing, toileting, and personal hygiene. He had an indwelling catheter and was always incontinent of bowel. Review of Resident #64's care plan dated 10/12/22 revealed: Resident #64 was at risk for impaired communication related to expressive aphasia. The interventions included allow a calm, unhurried environment to encourage communication and anticipate the Resident's needs.	F 600	F-600D Free from abuse and neglect 483.12 1.The facility failed to ensure that a resident was free from neglect when resident #64 did not receive care upon request by a family member after a vomiting episode and incontinence episode. An initial allegation report was submitted by the Director of Nursing (DON) to Department of Health and Human Services (DHHS) on 12-1-22 after being notified by a State survey agency of the allegation of neglect. An investigation was initiated by the Director of Nursing on 12-1-22 . Current staff education on resident abuse and customer service was initiated by the Assistant Director of Nursing on 12-1-22. The investigation was completed and was unsubstantiated based on resident #64 spouses□ interview, and staff interviews. The investigation report was completed by the Director of Nursing on 12/06/2022 and submitted to the DHHS. The facility received a report from the North Carolina Department of Health and Human services Registry section on December 13th indicating no additional investigation was necessary. Staff that were identified as working with the resident #64 on the evening of 10-31-22 were interviewed and received education by the Director of Nursing as part of the investigation which was completed on 12/6/2022. The police did come to the facility on 12-1-22 and the family member did not want to press any charges. Resident # 64 remains in the facility currently and has had no changes	

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F 600	Continued From page 2 Resident #64 had difficulty making decisions related to a stroke. The interventions included assist with activities of daily living and mobility as needed. Monitor activities of daily living for needed assistance and render care as needed. Monitor Resident #64 for changes in condition. Resident #64 was at risk for pressure ulcer related to assistance required for bed mobility and bowel incontinence. The interventions included provide skin care after incontinence episodes and apply barrier cream. During an interview on 11/28/22 at 1:08 PM Resident #64's family member indicated after requesting care, they sometimes had to wait extended periods of time for that care to be provided. The family revealed on the night before Resident 64's hospitalization, he was not feeling well and had an episode of vomiting and diarrhea. She further revealed Resident #64 had vomit all over his shirt and had soiled his brief. The family asked for assistance from a Nurse Aide (NA) on the hall, she told the NA Resident #64 had vomited and had soiled his brief. The NA came to the room door and told her she had 23 residents and was getting ready to start her rounds. The family member was also told by the NA, she started her rounds at one end of the hall and worked her way around and she would get to Resident #64 when she could. The family member stated, "I cleaned his shirt up the best I could until the NA came back". The family watched the time and the Nurse Aide returned 45 minutes later and provided the care. She further stated she did not recall the name of the nurse aide; she just knew it happened the night before Resident #64's hospitalization. The next morning,	F 600	recently. 2. All residents on 200 Hall could potentially be affected by this deficient practice. Alert and oriented residents on 200 halls were interviewed by the social worker on 12-1-22 and no concerns of neglect or abuse were identified. Non-alert and oriented residents on 200 hall had skin checks completed by nursing staff by 12/24/2022 with no issues noted. 3. Current staff received education by the Assistant Director of Nursing and the Staff Development Coordinator on the abuse and neglect protocol which included the expectation to receive assistance when requested by a resident and /or family member with examples such as receiving incontinent care and assistance with being cleaned after vomiting episodes upon request. This education was completed on 12/26/2022 by the Assistant Director of Nursing and the Staff Development Coordinator. This education will be a part of orientation to include use of agency staff and provided by The Assistant Director of Nursing/Staff Development Coordinator. 4. DON will conduct 5 random interviews weekly x 12 weeks with family members and /or alert and oriented residents regarding care and service being provided upon request. Any concerns identified will be addressed immediately by the Director of Nursing. DON will present the findings to Quality assurance and process improvement	

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F 600	Continued From page 3	F 600		

she reported what happened to the oncoming Nurse. The family member revealed this was not the 1st time Resident #64 had to lay with a soiled shirt on. Sometimes when she came in the morning, Resident #64 would have dried up matter on his shirt. She thought this was happening because the facility did not have enough staff.

Review of Resident #64's Electronic medical record (EMR) revealed he was transferred to the hospital on 11/1/22.

Review of the staffing sheets revealed NA #1 and NA #3 were assigned to work A and B halls on the evening of 10/31/22. Medication Aide (MA) #2 was assigned to work as Float NA on the night of 10/31/22 and Nurse #3 was assigned to work A and B halls on the morning of 11/1/22.

During an interview on 12/1/22 at 10:22 AM with Nurse #2 revealed she did staffing/scheduling for the facility. She stated there was usually 1 NA scheduled to provide care for both A and B halls. C hall was staffed with 1 NA, D hall was staffed with 1 NA, and there was an NA to float between C and D halls because the residents on those halls were more dependent.

During an interview with MA #2 on 12/1/22 at 1:30 PM she revealed she did not recall working with Resident #64 on 10/31/22. She usually worked as a MA, but she occasionally worked as a NA. She further revealed did not recall floating on A/B halls or caring for Resident #64.

On 12/1/22 at 1:34 PM a telephone interview was conducted with NA #1 where she revealed the facility was short staffed. There were typically 2

(QAPI) meeting to evaluate effectiveness and make changes if indicated.

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F 600	Continued From page 4	F 600		

or 3 nurse aides working on her shift and being short staffed slowed down the process of getting to each resident to provide care. When she started her shift, she gathered her supplies and began her rounds. She stated, "I start my rounds at one end of the hall and work my way around". She revealed she was familiar with Resident #64. He was a resident with Parkinson's that required two person assist and repositioning on B hall. During the interview NA #1 initially stated she worked on the night before Resident #64 was transferred to the hospital, 10/31/22. She indicated Resident #64 may have vomited that night. She stated, "he holds his meds in his mouth and then he would spit them back out or throw it up, he had a habit of doing that". She recalled notifying his nurse about having blood in his catheter on that night. This surveyor asked NA #1 did she recall Resident 64's family requesting assistance because he vomited on his shirt and had an episode of diarrhea. She stated she did not recall that, and she was not sure if she was working that night. At the end of the interview NA #1 stated, "I just looked at my calendar, I did not work that night".

Review of the clock in sheet for 10/31/22 revealed NA #1 clocked in at 6:54 PM on that date and clocked out at 5:22 AM on 11/1/22.

Review of ADL documentation report revealed NA #1 documented in Resident #64's EMR on 10/31/22.

During a follow up interview with Resident #64's family member on 12/1/22 at 2:45 PM she revealed she could not remember the name of the nurse aide that cared for Resident #64 on the night before he went to the hospital. She

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described the NA as 5'6" to 5'8", slim with reddish shoulder length hair that she wore pulled back. She stated on that night she was upset "I just sat here and cried; I was afraid he may have swallowed his vomit". She remembered that the nurse she reported this to was Nurse #3. She further stated on the day Resident #64 returned from the hospital the same NA was there again.

An interview was conducted with Nurse #2 on 12/1/22 at 5:45 PM she described NA #1 as tall, medium build with red hair that she sometimes wears in a ponytail.

Review of Resident #64's EMR revealed he returned to the facility from the hospital on 11/11/22.

Review of the staff assignment sheet revealed NA #1 was assigned to A/B halls on 11/11/22.

During an interview with Nurse #3 12/1/22 at 3:58 PM she revealed she cared for Resident #64 on the day he transferred to the hospital, 11/1/22. She stated Resident #64's family told her that on the night before they had requested assistance from the NA because the resident had vomited and had a bowel movement. The NA did not clean him up until later that shift. Nurse #3 revealed the NA that cared for Resident #64 on the night of 10/31/22 was NA #1.

During an Interview on 12/1/22 at 3:04 PM with the Director of Nursing she revealed she was unaware of any concerns regarding Resident #64, she did not know the family requested care and had to wait and extended time before care was provided. No one had reported this to her. She stated if a resident or family requested care,

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F 600	Continued From page 6 she expected staff to provide the care right away and to report the vomiting to the nurse.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and family interview the facility failed to implement	F 607	F-607D Develop/implement abuse/neglect policies	12/26/22

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F 607	Continued From page 7 their abuse and neglect policy in the area of reporting. Nurse #3 failed to report an allegation of neglect to facility administration after the allegation was reported directly to her, therefore a report to the state was not done. This occurred for 1 of 1 sampled resident (Resident #64). The findings included: A policy titled Abuse, Neglect, Exploitation and Misappropriation Program dated April 2021 read in part, the resident abuse, neglect, exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: -Identify all possible incidents of abuse and neglect. -Investigate and report any allegations within the timeframes required by federal requirements. During an interview on 11/28/22 at 1:08 PM Resident #64's family member revealed on the night before Resident 64's hospitalization, he was not feeling well and had an episode of vomiting and diarrhea. She further revealed Resident #64 had vomit all over his shirt and had soiled his brief. The Family asked for assistance from a Nurse Aide (NA) on the hall, she told the NA Resident #64 had vomited and had soiled his brief. The NA came to the room door and told her she had 23 residents and was getting ready to start her rounds. The family member was also told by the NA, she started her rounds at one end of the hall and worked her way around and she would get to Resident #64 when she could. The family member stated, "I cleaned his shirt up the best I could until the NA came back". The family watched the time and the Nurse Aide returned 45	F 607	1.The facility failed to implement their abuse and neglect policy regarding reporting, as nurse #3 failed to report an allegation of neglect to facility administration after the allegation was reported directly to her for resident #64. An initial allegation report was submitted by the Director of Nursing (DON) to Department of Health and Human Services (DHHS) on 12-1-22 after being notified by a State survey agency of the allegation of neglect. An investigation was initiated by the Director of Nursing on 12-1-22. Current staff education on resident abuse and customer service was initiated by the Assistant Director of Nursing on 12-1-22. The investigation was completed and was unsubstantiated based on resident #64 spouses interview, and staff interviews. The investigation report was completed by the Director of Nursing on 12/6/2022 and submitted to the DHHS. Nurse #3 was interviewed during the investigation and received education by the Director of Nursing on reporting allegations of neglect to facility administration. Resident # 64 remains in the facility currently and has had no changes recently. 2. All residents on 200 Hall could potentially be affected by this deficient practice. Alert and oriented residents on 200 halls were interviewed by the social worker on 12-1-22 and no concerns of neglect or abuse were identified. Non-alert and oriented residents on 200 hall had skin checks completed by nursing staff by 12/24/2022 with no issues noted.	

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F 607	Continued From page 8 minutes later and provided the care. She further stated she did not recall the name of the nurse aide; she just knew it happened the night before Resident #64's hospitalization. The next morning, she reported what happened to the oncoming Nurse, Nurse #3. Review of nurse notes revealed no notes regarding the allegation reported by Resident 64's family member. There were also no notes of the allegation being reported to administration. During an interview with Nurse #3 12/1/22 at 3:58 PM she revealed she cared for Resident #64 on the day he transferred to the hospital, 11/1/22. She stated Resident #64's family told her that on the night before they had requested assistance from the NA because the resident had vomited and had a bowel movement. The NA did not clean him up until later that shift. Nurse #3 revealed the NA that cared for Resident #64 on the night of 10/31/22 was NA #1. Nurse #3 did not indicate if she had reported this care concern to administration. During an interview on 12/1/22 at 3:04 PM with the Director of Nursing she revealed she was unaware of any concerns regarding Resident #64, she did not know the family requested care and had to wait and extended time before care was provided. No staff had reported this to her. She stated if a resident or family requested care, she expected staff to provide the care right away and to report the vomiting to the nurse.	F 607	3 Current staff received education by the Assistant Director of Nursing and Staff Development Coordinator on the abuse and neglect protocol which included the expectation to report to administration immediately any allegations of neglect with examples such as receiving incontinent care and assistance with being cleaned after vomiting episodes upon request. This education was completed on 12/26/2022 by Assistant Director of Nursing and Staff Development Coordinator. This education will be included in orientation of new hires to include any agency staff by the Assistant Director of Nursing/Staff Development Coordinator. 4 Director of Nursing will conduct 5 random interviews weekly x 12 weeks with family members and/or alert and oriented residents regarding care and service being provided upon request. Any concerns identified will be addressed immediately by the Director of Nursing. DON will present the findings to Quality assurance and process improvement (QAPI) meeting to evaluate effectiveness and make changes if indicated.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		12/26/22

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F 641	Continued From page 9 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code an annual Minimum Data Set assessment for the presence of a level 2 Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASRR. (Resident #53) The findings included Resident #63 was admitted to the facility on 06/28/21 with diagnoses that included schizoaffective disorder, bipolar disorder, and unspecified mood disorder. A review of Resident #63's electronic documents revealed a document titled "PASRR Level II determination Notification" dated 12/10/21 identifying Resident #63 was appropriate, and provided, a level II PASRR. A review of Resident #63's most recent annual Minimum Data Set (MDS) assessment dated 06/30/22 had Resident #63 as not having a level II PASRR. During an interview with MDS Nurse #1 on 12/01/22 at 1:56 PM, she reported while she was not the MDS Nurse who completed Resident #63's annual MDS assessment, if Resident had a level II PASRR at the time it was completed, it should have been coded as such. MDS Nurse #2 was unable be interviewed. During an interview with Corporate Consultant #1	F 641	F- 641 D Accuracy of assessment 483.20 1.The facility failed to accurately code an annual Minimum data set (MDS) for the presence of a level 2 Preadmission screening and resident review (PASRR) for resident #53. The Annual MDS with Assessment reference date (ARD) of 6/30/22 was modified by the MDS coordinator on to reflect a level 11 PASRR. 2.All level 2 residents have the potential to be affect by this deficient practice. The MDS nurse #2 and corporate consultant completed a 100% audit of the current Level 2 residents comprehensive assessments and found no further issues on 12/22/2022 . 3.Education was provided to MDS nurses and social workers by corporate consultant on 11/28/2022 using the RAI manual on Section A PASRR coding. This education will be provided to any new MDS or social worker hires by the Lead MDS nurse. 4.Director of Nursing (DON) will conduct 5 random audits on the comprehensive MDS s weekly to determine if the PASRR coding was coded accurately x 12 weeks and the results of these audits will be reported to Quality Assurance	

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F 641	Continued From page 10 on 12/01/22 at 2:09 PM, she reported the inaccuracy of Resident #63's PASRR was most likely an oversight. During an interview with the Director of Nursing on 1201/22 at 3:17 PM, she reported she expected MDS assessments to be coded correctly. She stated she could not answer why or how Resident #63's PASRR level was coded incorrectly. She reported she believed PASRR status used to prepopulate within the MDS assessment but stated the inaccuracy should have been caught by the MDS Nurse that completed the assessment and coded correctly before being closed and submitted.	F 641	Performance Improvement meeting to evaluate the effectiveness. The QAPI will make recommendations/changes as needed. to determine if the PASRR coding was coded accurately.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		12/26/22

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F 692	Continued From page 11 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to carry out and implement nutritional interventions recommended by the Registered Dietician for a resident with significant weight loss following a hospitalization for 1 of 6 residents reviewed for nutrition (Resident #55). The findings included: Resident #55 was readmitted to the facility on 10/04/22 with diagnoses that included acquired absence of part of digestive tract, dysphagia, chronic obstructive pulmonary disease, and others. Review of a physician order dated 10/17/22 read, regular mechanical soft diet with nectar consistency, liquid nutritional supplement 120 milliliters (ml) at bedtime and offer bedtime snack. Review of the Registered Dietician (RD) progress note dated 10/20/22 read in part, Resident #55 re-entered the facility after a 10/04/22-10/17/22 hospital stay. Work up was completed and he was diagnosed with sepsis (infection) related to urinary tract infection and pneumonia along with associated pulmonary embolism. Set up assistance of one staff to eat and intakes noted at 50-75%. He is refusing the liquid nutritional supplement. The recommendations included: discontinue liquid nutritional supplement-it is not nectar thick liquid and he is refusing. Add frozen nutritional supplement on lunch and dinner tray in addition to regular dessert.	F 692	F 692D Nutrition/hydration status/maintenance 483.25 1. The facility failed to carry out and implement nutritional interventions recommended by the Registered Dietician for resident #55. The nutritional recommendation was implemented on 12/1/2022 by the unit Manager. The Medical Doctor was informed by the Director of Nursing of the resident□s current nutritional status on 12/1/2022. The responsible party was notified by the unit Manager on 12/1/2022 of the resident□s current nutritional status. 2. All residents have the potential to be affected by this deficient practice. An audit of nutritional recommendations of the past 30 days were reviewed was completed by Dietary Manager and Unit Manager on 12/1/2022 with no other issues noted. 3. Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator will educate the licensed nursing staff and the dietary manager on the initiation of dietary recommendations and will be completed by 12/26/22. This education will be provided to new licensed nurse hires during the orientation process and for agency licensed nursing staff by the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator.	

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F 692	Continued From page 12 Review of a care plan revised on 10/20/22 read in part, Resident #55 was at risk for alteration in nutritional and hydration status related to need for mechanically altered diet for dysphagia, significant weight loss, self-feeding difficulties, and decline in intakes. The interventions included supplements as ordered. Review of Resident #55's medical record revealed no order to discontinue liquid nutritional supplement or for the addition of frozen nutritional supplement. Review of Resident #55's weight record revealed the following weights: 09/29/22-168 pounds (lbs.) 10/17/22-147 lbs. 11/01/22-150 lbs. Review of the most recent Medicare 5-day Minimum Data Set (MDS) dated 10/24/22 revealed that Resident #55 was moderately impaired for daily decision making. The MDS further revealed that Resident #55 required set up assistance with eating, weighted 147 lbs. and had a 5% or more weight loss in the last month or 10% weight loss in six months and received a mechanically altered diet. An observation of Resident #55's lunch tray was made on 11/28/22 at 12:34 PM. There was no frozen nutritional supplement noted on the lunch tray. An observation of Resident #55's lunch tray was made on 11/30/22 at 11:54 AM. No frozen nutritional supplement was noted on the meal tray.	F 692	4. Dietary recommendations will be reviewed by the DON in weekly risk meeting x 12 weeks for prompt implementation. The DON will present to findings to the Quality assurance process improvement (QAPI) meeting to evaluate effectiveness. QAPI committee will make changes and recommendations as indicated.	

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An interview was conducted with the RD on 11/30/22 at 12:46 PM. The RD explained she visited the facility twice a month and once she had evaluated the residents she needed to, she sent via email her recommendations to the Director of Nursing (DON), Unit Manager, (UM), the Administrator, and to the Dietary Manager (DM) and they processed and implemented the recommendations. The RD stated that Resident #55 had a significant weight loss following his hospitalization and had gained a few pounds since readmitting to the facility, but the facility continued to monitor his weights per their protocol.

The DM was interviewed on 11/30/22 at 5:43 PM. The DM stated that each time the RD visited the facility she would take the recommendations to the UM, and we would discuss them and go over them. The DM stated she would enter the orders into the dietary system to print on the resident's tray ticket and the UM would enter the orders into the resident's electronic medical record. The DM stated she was not sure how the recommendations from the RD on 10/20/22 got missed but she would correct the issue immediately.

An observation of Resident #55's dinner tray was made on 11/30/22 at 5:54 PM. There was thickened liquid on the tray but there was no frozen nutritional supplement noted on the tray.

The DON was interviewed on 12/01/22 at 11:14 PM. The DON stated that the UM and the DM would take the recommendations provided by the RD and go over them. The UM would enter the order into the medical record and the DM would

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F 692	Continued From page 14 enter the recommendation into the dietary system to be printed on the resident's meal ticket. The DON stated that they discussed the residents with weight loss during their weekly risk meeting and probably saw he was receiving liquid nutritional supplement and thought he was covered from a supplement standpoint. The UM was interviewed on 12/01/22 at 2:25 PM. The Um stated she was not sure what happened with the recommendations from the RD on 10/20/22 but generally she and the DM sat down and went over the recommendations together and she would enter the order and the DM would enter them on her end. The UM stated that she did not think Resident #55 would take the frozen nutritional supplement because he liked things at room temperature.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		12/26/22

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F 725	Continued From page 15 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, staff interview and family interviews the facility failed to provide sufficient nurse staffing to provide care for residents dependent on staff for assistance. This occurred for 2 of 2 sampled residents (Resident #64 and Resident #31). The findings included: This tag is cross-referenced to F600: Based on record review, staff interviews and family interview the facility failed to ensure that a resident was free from neglect when it failed to provide the care after requested for 1 of 1 sampled resident (Resident #64) who required extensive assistance and had an episode of vomiting and incontinence. The reasonable person concept was applied to this deficiency. Individuals would expect to receive the care needed and would be upset wearing a shirt soiled with vomit and wearing a soiled brief after requesting assistance. During an interview on 11/29/22 at 10:13 AM with Resident #31 who was cognitively intact revealed when she needed assistance staff told her that	F 725	F-725 D Sufficient Nursing Staff 483.35 1.The facility failed to ensure that a resident was free from neglect when it failed to provide the care requested by a resident who required extensive assistance and had an episode of vomiting and incontinence care for a resident dependent on staff for assistance resident # 64 and a resident who waited too long for care resident # 31. Resident # 64 and Resident # 31 both reside in the facility and have had no further concerns and are interviewed frequently. 2.All residents have the potential to be affected by this deficiency. Interviews were conducted with alert and oriented residents and available family members regarding care and services provided on 12/1/2022 and will all be completed by 12/26/22 and any issues noted were taken care of immediately. 3.Licensed nursing staff, medication aides, certified nursing assistants and therapy staff will be educated to provide	

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F 725	Continued From page 16 they were the only NA on the hall, or they were pulled from another hall, and they didn't have much time to work with her. She further revealed, staff would come in her room turn off her call light and told her they'd be back, staff would not come back for hours if at all. She stated she had waited hours for incontinence care. During an interview with NA #4 on 11/30/22 at 9:36 AM he stated the facility was short staffed and he was responsible for 32 residents on that day. He frequently cared for that number of residents. He further stated there were many nurse aide students at the facility on that day and it was a big help. He revealed on a day where there were no students it was difficult to provide care. He typically answered all the call lights then prioritized what he thought was most important. He further revealed the facility was frequently short staffed and he was not always able to provide showers. He would give the residents bed baths and some days he could just "hit the hot spots". On 11/30/22 at 1:30 PM during an interview with Nurse #5 she stated staffing was bad, " We do not have enough staff; we do the best we can with what we have". She further stated there were usually 1 NA per hall and sometimes a float NA. The NA's had a difficult time getting to all the residents and getting them changed. She revealed often there was not enough staff to give showers. During an interview with Nurse #6 on 11/30/22 he revealed sometimes there was 1 NA per hall, and it took longer to provide care. He further stated staff provided care as quick as they could.	F 725	incontinent care and change soiled clothing upon resident request in a timely manner Staff Development Coordinator/Assistant Director of Nursing/ Director of Nursing. This will be completed on 12-26-22. This education will be provided to new hires during the orientation process by the Staff Development Coordinator/Assistant Director of Nursing, as well as to any agency staff. 4. A monitoring tool will be utilized and initiated by the Director of Nursing to interview/review 5 residents weekly x 12 weeks to ensure needs have been met. The DON will present findings of these reviews to the QAPI meeting to evaluate effectiveness. QAPI committee will make changes and recommendations as indicated.	

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F 725	Continued From page 17 During an Interview on 11/30/22 at 3:16 PM Nurse #4 revealed there was only 1 Resident Aide (RA) in the facility at that time. She stated, "It's a lot". Between 3pm and 5pm the were no nurse aides in the facility and nurses were responsible for answering call lights. An interview was conducted with Nurse #3 on 12/1/22 10:22 AM where she revealed the facility lost staff during the pandemic and staffing has been challenging since. They used 10-hour shifts and had recently added 8- and 12-hour shifts. With the varying shifts the facility had nurse aide holes daily from 3 PM to 5 PM, during this time nurses answered call lights and administration would help as needed. The facility utilized RAs, the RAs could pass ice, trays and answer call lights. The RAs could not provide patient care. During an interview with the Director of Nursing on 12/01/22 03:07 PM she indicated the facility had issues with staffing "we struggle". Administration helped on the unit, and they were working on different ways to increase staffing.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		12/26/22

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F 755	Continued From page 18 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Consultant Pharmacist, Pharmacy Director of Quality, and Medical Director interviews the facility failed to have an effective system in place to ensure staff did not have to borrow controlled substance medications from 3 of 3 residents (Resident #13, Resident #42, and Resident #69) to give to other residents whose medications were not available in the facility on 3 of 4 hallways (200, 300, and 400 hall) and failed to administer a physician ordered medication for 1 of 1 resident reviewed for psychotropic medications (Resident #21). The findings included: 1a. Resident #13 was admitted to the facility on	F 755	F755 E Pharmacy Services 483.45 1. The facility failed to have an effective system in place to ensure staff did not have to borrow controlled substance medications to give to other residents whose medications are not available. The facility failed to administer a physician order medication for Resident #21. An audit was conducted on 11/30/22 by the Director of Nursing using an order listing report for all active residents on antianxiety, hypnotics, analgesics, and opioids to confirm the medication was present on the medication cart. This included resident #13, #42, # 69 and	

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F 755	Continued From page 19 03/05/18 with diagnoses that included osteoarthritis. Resident #13 resided on the 300 hall. Review of a physician order dated 06/09/21 read, Hydrocodone/Acetaminophen 5/325 milligrams (mg) by mouth every 6 hours as needed for pain. Review of the quarterly Minimum Data Set (MDS) dated 10/21/22 revealed that Resident #13 was moderately cognitively impaired and required extensive assistance with activities of daily living. The MDS further revealed that Resident #13 reported no pain during the assessment reference period and received no opioid (pain) medication during the assessment reference period. Review of Resident #13's declining controlled substance log for Hydrocodone/Acetaminophen 5/325 mg revealed that the medication was borrowed from Resident #13 for a resident in room #308 A on 10/28/22, borrowed for a resident in room #309A on 11/09/22, and again on 11/16/22. 1b. Resident #42 was admitted to the facility on 11/22/19 with diagnoses that included osteoarthritis and dementia. Resident #42 resided on the 400 hall. Review of a physician order dated 03/16/22 read, Hydrocodone/Acetaminophen 5/325 mg by mouth every 8 hours as needed for pain. Review of the quarterly Minimum Data Set (MDS) dated 10/04/22 revealed that Resident #42 was moderately impaired for daily decision making and required extensive assistance with activities	F 755	Resident #21. On 11/29/22 the request for DEA form 222 was completed and transmitted successfully. The forms arrived on 12/5/2022 and the emergency kit-controlled substances were delivered on _12/23/2022 from pharmacy. The Medical Director was notified on 11/29/22 of the above findings with no new orders. 2. All residents with orders for controlled substances and psychotropic hypnotic medications are at risk for this deficient practice. An audit of Narcotic count sheets was completed on 11/28/2022 by Director of Nursing/ MDS Nurse and Corporate Consultant. No further issues were noted. 3. Education was initiated on 11/29/22 by the Assistant Director of Nursing and Staff Development Coordinator regarding not borrowing medications and the process for ordering controlled substances. Education also included the addition of the controlled substances now available in the emergency kit. This education was provided to the medication aides and the nurses and will be completed by 12/26/2022. This education will be provided to new licensed nursing hires during the orientation process and with any agency licensed nursing staff by the Staff Development Coordinator/Assistant Director of Nursing. 4. An order listing report will be used to identify all residents with new orders for controlled substances and	

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F 755	Continued From page 20 of daily living. The MDS further indicated that Resident #42 reported no pain and received no opioid medications during the assessment reference period. Review of Resident #42's declining controlled substance log for Hydrocodone/Acetaminophen 5/325 mg revealed that the medication was borrowed for a resident in room #206 A on 05/21/22, 06/11/22, 06/12/22, and 06/13/22. Borrowed for a resident in room #209B on 05/13/22. Borrowed for a resident in room #105 on 06/12/22. Borrowed for a resident in room #206 B on 07/03/22, 07/04/22, and 07/05/22. Borrowed for a resident in room #407 on 07/07/22. Borrowed for a resident in 416 B on 08/19/22 and borrowed for a resident in room #409 A on 09/24/22. 1c. Resident #69 admitted to the facility on 03/11/22 with diagnoses of metabolic encephalopathy. Resident #69 resided on the 200 hall. Review of a physician order dated 09/29/22 read, Morphine Sulfate 20 milligram (mg)/5 milliliters (ml) give 0.25 ml by mouth every 2 hours as needed. Review of the significant change Minimum Data Set (MDS) dated 09/30/22 revealed that Resident #69 was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #69 had no pain and received no opioid medication during the assessment reference period. Review of the declining controlled substance	F 755	psychotropic/hypnotic medications with an order listing report to CART audit validating the medications were received from the pharmacy. The narcotic count sheets will be reviewed weekly x 12 weeks by the DON/ADON/Unit Manager to ensure there is no documentation indicating meds were borrowed. The results of these audits will be reported to QAPI by the DON to evaluate effectiveness. QAPI will make recommendations/changes as indicated.	

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sheet for Resident #69's Morphine Sulfate 20 mg/5 ml indicated that the medication was borrowed for a resident in Room #110 on 10/24/22 (3 doses) and 10/25/22 (4 doses).

Nurse #6 was interviewed on 11/29/22 at 2:17 PM who confirmed that he generally worked on the 300 hall. Nurse #6 indicated that the staff had to borrow controlled substance medications frequently because there were none in the Omnicell (back up supply of medications). Nurse #6 stated that generally when they borrowed a medication it was because it was a new order and had not yet arrived from the pharmacy, so they borrowed the medication from another resident's supply while they waited for it to arrive from the pharmacy. Nurse #6 stated that at times he would have to contact the pharmacy if a medication did not arrive for several days and see what the issue was.

Nurse #5 was interviewed on 11/29/22 at 2:53 PM who confirmed that she generally worked on the 400 hall. Nurse #5 confirmed that the staff were borrowing controlled medications because there were no controlled medications in the Omnicell and to keep the residents from doing without they just borrowed from other residents. Nurse #5 stated that when she had to borrow a medication, she just documented on the declining controlled substance sheet.

Medication Aide (MA) #3 was interviewed on 11/29/22 at 3:47 PM who confirmed that she worked on 200 hall. MA #3 stated that when she needed a controlled substance, and they were not in the Omnicell she documented that they were out of the medication. MA #3 confirmed that she had to borrow controlled substances from other

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residents from time to time and would document the room number that she borrowed it for on the declining controlled substances log.

MA #2 was interviewed on 11/30/22 at 2:21 PM. MA #2 stated that she was new to working as a Medication Aide and she was not aware of any back supply of medication or Omnicell. She stated that as part of her training the staff instructed her if she was out of medication, she was to borrow from another resident who had the medication in stock. MA #2 stated that if she had to borrow a controlled substance, she would document it on the declining controlled substance log and would usually let her supervisor know but could not recall if she did that each time, she borrowed medication or not.

Nurse #7 was interviewed on 11/30/22 at 2:31 PM who confirmed she worked the night shift at the facility on 300 and 400 halls. Nurse #7 confirmed that they had to borrow controlled medications "quite often." She explained that on the night shift a lot of times the pharmacy would call and report that they could not read the prescription that was faxed over and then she had to go dig through the day's paperwork to find the prescription and re-fax it to the pharmacy which meant additional days before the actual medication arrived at the facility for use. Nurse #7 stated the Omnicell did not have any controlled medications in it and to keep the residents from doing without they borrowed the medication from other residents. Nurse #7 stated that in the past she had called the Director of Nursing (DON) about not having controlled medications in the Omnicell and was instructed to borrow the medication from another resident. We were trained that when a resident's stock of medication ran low, we were to re-order

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the medication.

MA #4 was interviewed on 11/30/22 at 2:40 PM who confirmed that she had to borrow medication frequently at the facility. MA #4 stated that the facility did not keep any controlled substances in their back up Omnicell since the new pharmacy took over. She stated that when she borrowed controlled substance, she had been instructed to document the room number she borrowed the medication for on the declining controlled substance log. MA #4 stated that the issue with medications has been ongoing, and she had in the past reported the issue to the Director of Nursing (DON).

The DON was interviewed on 11/29/22 at 3:58 PM and explained that when the facility transferred ownership in March 2022 there was an issue with getting the correct paperwork that allowed her to order the controlled substances for the Omnicell. Finally, in June or July of 2022 the DON stated she was able to order the forms that would allow her to order the controlled substances for the Omnicell, but they have never received them. The DON stated that earlier in the day (11/29/22) she had reached out to the pharmacy and was told she had to go to a website and print them off but had not done so yet. The DON stated that the staff had been instructed to clearly document on the declining controlled substance log who the medication was borrowed for. She stated she was unaware that the staff were only documenting the room number of the resident who borrowed the medication and that she was unaware that they were borrowing controlled substances frequently.

A follow up interview was conducted with the

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DON on 12/01/22 at 11:08 AM. She stated that "she had to do a lot of extra things due to staffing" and was not totally focused on "director of nursing things." The forms to order the controlled substances were ordered in June or July of 2022 and then I "never really thought about it again" until now. When a resident was out of controlled substances or in need of a controlled substances that we did not have, the staff should be contacting me as well as the pharmacy to get the medication en route before we borrow from another resident.

The Consultant Pharmacist (CP) was interviewed via phone on 11/29/22 at 4:45 PM who stated that he visited the facility once a month to "check on them." The Consultant Pharmacist stated his last visit to the facility was November 18, 2022, and while onsite he would go through and conduct a medication cart and medication room audit and anything else that was needed. He continued to say that he used to conduct a "narcotic destruction with the facility" but now they returned all unused narcotics to the pharmacy. The Consultant Pharmacist stated that "he had no knowledge of borrowing narcotics" in the facility. The DON reported earlier today (11/29/22) that she had an issue with the Omnicell but prior to that he had no knowledge of any issues with ordering-controlled substances or that the facility was borrowing controlled substances which should only be done in an emergency. The Consultant Pharmacist stated that he was unaware of the facility's procedure for controlled substances but stated he would never approve the borrowing of controlled substances for more than a onetime emergency until the pharmacy could provide the medication because he believed the facility received deliveries from the

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pharmacy between five to six days a week.

The Pharmacy Director of Quality was interviewed via phone on 11/30/22 at 1:23 PM who stated that she was unaware of the issue with ordering-controlled substances for the facility's Omnicell and was unaware that the facility was borrowing controlled substances. The Pharmacy Director of Quality stated that "we absolutely do not recommend borrowing" of controlled substances. The staff should be first checking their Omnicell to see if the medication was there and if not, they should be contacting the pharmacy even after hours. The pharmacist would then determine if it would be quicker to send the medication from the pharmacy as a "stat" or have it filled at a local pharmacy. She added that most time it was more efficient and quicker to have the pharmacy fill the medication and send it to the facility with a 4-hour turnaround time because they hold the current prescription for the medication. In order to have it filled at local retailer they would have to get a prescription from the provider. The Pharmacy Director of Quality was unable to say if the Consultant Pharmacist was to review the narcotic declining controlled substance log or not because she was not certain how "his contract was set up."

The Medical Director (MD) was interviewed via phone on 11/29/22 at 5:06 PM. The MD stated that he was aware from time to time they had to borrow a controlled substances but was not aware that it was being done frequently. He stated that he was also unaware of any issue regarding the ordering of controlled substances for the Omnicell. The MD stated he would have to communicate with the facility to get the issue resolved.

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2. Resident #21 was admitted to the facility on 09/19/22 with diagnoses that included restless leg syndrome, systemic Lupus, and insomnia.

A review of Resident #21's admission Minimum Data Set (MDS) assessment dated 09/26/22 revealed her cognition was severely impaired and received hypnotics 4 nights in the look back period.

A review of Resident #21's physician order dated 09/19/22 revealed an order for Restoril Capsule (given to induce sleep) 15 milligrams (mg), give one capsule by mouth every night for sleep.

A review of Resident #21's Medication Administration Record (MAR) for November 2022 revealed:

On 11/25/22 the Restoril scheduled for 8:00 PM was documented as not given by Nurse #1 and charted as a number 4 which meant to see the progress note.

A review of Resident #21's progress notes on 11/25/22 1:03 AM by Nurse #1 that the Restoril was on order from the pharmacy.

On 11/26/22 the Restoril scheduled for 8:00 PM was documented as not given by Nurse #1 and charted as a number 4 which meant to see the progress note.

A review of Resident #21's progress notes revealed documentations on 11/26/22 11:54 PM by Nurse #1 that the Restoril was unavailable at this time and the printed order had to be signed by the physician.

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On 11/27/22 the Restoril scheduled for 8:00 PM was documented as not given by the Unit Manager #1 and charted as a number 4 which meant to see the progress note.

A review of Resident #21's progress notes revealed documentations on 11/27/22 9:36 PM by Unit Manager #1 that the Restoril was not available. The script was sent to the pharmacy and the physician was aware. Order to continue to hold until dose arrived then resume as scheduled.

On 11/28/22 the Restoril scheduled for 8:00 PM was documented as not given by Medication Aide (MA) #1 and charted as a number 4 which meant to see the progress note.

A review of Resident #21's progress notes revealed documentations on 11/28/22 7:48 PM by Medication Aide #1 that the Restoril was not available, and the medication had not yet arrived from the pharmacy.

An interview conducted with Resident #21 on 11/30/22 9:09 AM revealed the Resident was alert and answered questions appropriately. The Resident reported that she had not been given her sleeping medication for several nights in a row and stated when she asked about the sleeping pill the nurses kept telling her that the medication had not been delivered from the pharmacy. The Resident explained that she had Lupus and her legs ached especially at night and she needed the sleeping medication to help her rest and without it she had to endure several sleepless nights. The Resident stated she should not have to go without her sleeping medication.

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An interview conducted with Nurse #1 on 12/01/22 8:54 PM revealed the Nurse confirmed that she worked 11/25/22 and 11/26/22 on the night shifts and did not have Resident #21's Restoril available to give her. The Nurse explained that the reorder sticker had been pulled from the medication card and it had already been reordered from the pharmacy so she thought the medication would be delivered from the pharmacy later those nights, but it was not. The Nurse continued to explain that on the night of 11/28/22 Medication Aide #1 reported to her that she did not have the Restoril available to give Resident #21 so she called the pharmacy and they told her that they needed a signed prescription for the medication before they could send it. The Nurse stated the next morning on 11/29/22 she had the Unit Manager show her how to print the prescription for the medication and put the prescription in the Physician's book so they could sign the prescription and it could be faxed to the pharmacy so the medication could be delivered. The Nurse added, the facility did not stock controlled medications in their back up stock medications.

During an interview with Unit Manager (UM) #1 on 11/30/22 4:18 PM the UM confirmed that she worked the night of 11/27/22 and did not give Resident #21 her sleeping medication because it was not available from the pharmacy. The UM explained that the nurses would usually let her know that the prescription medications were running low a few days before they ran out but in Resident #21's case with the sleeping medication she could not remember if she was told. She continued to explain that she obtained a signed prescription for the Restoril the next day and

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faxed it to the pharmacy. She indicated that she did not know why the medication was not delivered before the next medication pass on 11/28/22. The UM stated it was unacceptable for Resident #21 to go without her sleeping medication for four nights.

An interview was conducted with Medication Aide (MA) #1 on 11/29/22 5:16 PM who confirmed that she worked on the evening of 11/28/22 and was not able to give the Temazepam that night because it was not available from the pharmacy. The MA stated she informed Nurse #1 of not having the medication available.

During a follow up interview with Pharmacist on 11/30/22 3:22 PM the Pharmacist explained that the pharmacy records indicated that the facility requested a refill for the Restoril on 11/22/22 before they ran out of the medication, which was what the facility should have done, and a signed prescription was sent to the pharmacy on 11/29/22 and the Restoril was delivered to the facility on that day (11/29/22). She stated that she determined the pharmacy did not reach out to the Physician for a new script based on the 11/22/22 request, but she was unable to determine why that was not done. The Pharmacist stated the pharmacy could have even taken a verbal order from the Physician over the phone.

On 12/01/22 10:45 AM during an interview with the Director of Nursing (DON) she explained that she felt that the difficulty in getting the prescription medication from the pharmacy was because it happened over the weekend of Thanksgiving and that Nurse #1 was a fairly new nurse to the facility and needed to be reeducated to the procedure of ordering prescription

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F 755	Continued From page 30 medications over the weekends. The DON continued to explain that the facility did not keep controlled medications in their back up stock medications (Omnicell), but the Providers could have called the pharmacy and given a verbal order for the Restoril if needed which was what should have been done. An interview was conducted with the Physician on 12/01/22 11:10 AM. The Physician stated that he was not aware of Resident #21 going without the Restoril and it was not acceptable for the Resident to go without her Restoril. The Physician stated the situation could have been handled with a verbal order over the telephone to the pharmacy.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, Resident, and Physician interviews, the facility failed to prevent a significant medication error when they failed to obtain and administer a sleeping medication as ordered by the Physician for 1 of 1 resident reviewed for medications. A result Resident #21 missed 4 doses of the sleeping medication. The finding included: Resident #21 was admitted to the facility on 09/19/22 with diagnoses that included restless leg syndrome, systemic Lupus, and insomnia.	F 760	F760 E 483.25 Residents free from significant med errors 1. Resident # 21 failed to receive sleeping medication x 4 days. MD notified immediately that Resident #21 failed to received medications 4 days. Medications obtained immediately. Nurse #1 re-educated by the Director of Nursing on process for obtaining medications for new admissions or medications that are not on the cart. 2. All residents who are ordered sleeping	12/26/22

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F 760	Continued From page 31 A review of Resident #21's admission Minimum Data Set (MDS) assessment dated 09/26/22 revealed her cognition was severely impaired. A review of Resident #21's physician order dated 09/19/22 revealed an order for Restoril Capsule (given to induce sleep) 15 milligrams (mg), give one capsule by mouth every night for sleep. A review of Resident #21's Medication Administration Record (MAR) for November 2022 revealed: On 11/25/22 the Restoril scheduled for 8:00 PM was documented as not given by Nurse #1. On 11/26/22 the Restoril scheduled for 8:00 PM was documented as not given by Nurse #1. On 11/27/22 the Restoril scheduled for 8:00 PM was documented as not given by the Unit Manager #1. On 11/28/22 the Restoril scheduled for 8:00 PM was documented as not given by Medication Aide (MA) #1. An interview conducted with Resident #21 on 11/30/22 9:09 AM revealed the Resident was alert and answered questions appropriately. The Resident reported that she had not been given her sleeping medication for several nights in a row and stated when she asked about the sleeping pill the nurses kept telling her that the medication had not been delivered from the pharmacy. The Resident explained that she had Lupus and her legs ached especially at night and she needed the sleeping medication to help her rest and without it she had to endure several sleepless nights. The Resident stated she should not have to go without her sleeping medication.	F 760	medication have the potential to be affected by this deficient practice. The Director of Nursing/ Assistant Director of Nursing/Staff Development completed an order to cart audit on 11/28/2022 of all sleeping medication to ensure availability. No additional issues were noted. 3. The Director of Nursing/ Assistant Director of Nursing/Staff Development will reeducate all licensed staff/medication aids on process for obtaining medications not on the cart. This education will be provided to new hires upon orientation by the Assistant Director of Nursing/Staff Development Coordinator and will include any agency staff. This education will be completed on 12/26/2022 4. The Director of Nursing/ Assistant Director of Nursing/Staff Development will complete random audit on 5 residents per week to ensure residents have medications on cart as ordered x 12 weeks. The Director of Nursing will report these findings to the Quality Assurance Performance Improvement meeting. The QAPI will evaluate for recommendations and changes as needed.	

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An interview conducted with Nurse #1 on 12/01/22 8:54 PM revealed the Nurse confirmed that she worked 11/25/22 and 11/26/22 on the night shifts and did not have Resident #21's Restoril available to give her.

During an interview with Unit Manager (UM) #1 on 11/30/22 4:18 PM the UM confirmed that she worked the night of 11/27/22 and did not give Resident #21 her sleeping medication because it was not available from the pharmacy. The Nurse stated it was unacceptable for Resident #21 to go without her sleeping medication for four nights.

An interview was conducted with Medication Aide (MA) #1 on 11/29/22 5:16 PM who confirmed that she worked on the evening of 11/28/22 and was not able to give the Restoril that night because it was not available from the pharmacy.

An interview was conducted with the Physician on 12/01/22 11:10 AM. The Physician stated it was not acceptable for Resident #21 to go without her Restoril and the situation could have been handled with a verbal order to the pharmacy over the telephone.