STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/12/22 through 12/15/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 5EF911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/12/22 through 12/15/22. The following intakes: NC00186707, NC00188050, NC00188116, NC00190646, NC00194608, NC00194959, NC00195364 and NC00195587 were investigated and 11 of the 23 allegations were substantiated. See Event ID #5EF911.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		1/12/23

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

Electronically Signed | 01/09/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure staff spoke to residents in a respectful and dignified manner for 1 of 3 residents reviewed for dignity (Resident #51). The findings included Resident #51 was admitted to the facility on 09/30/22 with diagnoses that included chronic pain syndrome, dislocation of left and right shoulder joint, altered mental status, and depression. A review of Resident #51's quarterly Minimum Data Set Assessment revealed Resident #51 to be cognitively intact.	F 550	The statements included in this plan of correction are not an admission of guilt and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remail in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #51 was interviewed by the Administrator on 12/14/2022 for any	

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F 550	Continued From page 2 During an interview with Resident #51 on 12/14/22 at 10:05 AM, she reported she recently had an interaction with a nurse aide (NA #3) who was being mean to her while assisting her to bed. Resident #51 reported she began to cry and Resident #51 stated NA #3 then told her "we don't care for babies around here". Resident #51 stated she became more upset, and that NA #3 made her feel like her feelings were unimportant. During an interview with NA #3 on 12/14/22 at 3:48 PM, she reported she remembered the interaction and stated she felt Resident #51 misunderstood what she said. She reported that night, she was assisting Resident #51 to bed and noticed that she was crying and upset. NA #3 stated she asked her multiple times what was wrong with no answer from Resident #51. She then told Resident #51 that "we were all adults here and we don't cry. Babies cry" and that Resident #51 needed to tell her what was wrong. NA #3 stated she was eventually able to get her comfortable and her calmed down. She stated although she believed that Resident #51 misunderstood what she was saying, she agreed that the verbiage was not appropriate, and she should not have compared Resident #51's behavior that evening to the behavior of babies. During an interview with the Director of Nursing on 12/15/22 at 11:58 AM, she reported she was aware of the interaction between NA #3 and Resident #51. She reported staff should not be comparing actions of residents to the actions of children or babies. She stated she expected her staff to "resolve issues, not add to them". During an interview with the Administrator on	F 550	additional concerns since the interaction with Certified Nursing Assistant (CNA) #3. No additional concerns were voiced by the resident regarding dignified care. Social Worker interviewed Resident #51 on 12/19/2022 and offered support. CNA #3 was provided education on treating resident with dignity and respect on 12/14/2022 by the Administrator. 100% audit of all interview able residents was initiated by Director of Nursing or Designee on 12/19/2022 to ensure staff are speaking to residents in a dignified manner. This audit was completed on 1/6/2023. The Director of Nursing or designee initiated a 100% audit for all non-interview able residents, by contacting the Responsible Party regarding any concerns of staff not treating the resident in a dignified manner. This audit was completed on 1/6/2023. Any voiced concerns were addressed by Social Worker or designee by 1/12/2023. The Director of Nursing or designee completed an in-service on 1/12/2023 for all staff on resident rights and dignity. Any staff who did not receive this in-service by 1/12/2023 will not be allowed to work until this education has been completed. This education was added to the new hire employee orientation on 12/27/2022 by the Administrator. The Director of Nursing or Designee will interview 10 random interview able residents or family members of non-interview able residents weekly X 4	

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F 550	Continued From page 3 12/15/22 at 12:36 PM, she reported she was aware of the interaction between Resident #51 and NA #3. She reported she investigated it when she was made aware of the incident and educated NA #3 on customer service. She stated she expected her staff to speak to residents in a dignified and respectful manner.	F 550	weeks, then 5 random interview able residents or family members of non-interview able residents weekly X 4 weeks, then 5 random interview able residents or family members of non-interview able residents monthly X 1 month. The Director of Nursing or Designee will bring these audits to the Quality Assurance Committee meeting x 3 consecutive meetings, at which time a determination will be made if further monitoring is necessary. Completion Date: 1/12/2023	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure a resident's need was accommodated resulting in a resident who was mobile in a standard wheelchair being placed in a large reclining chair on wheels which inhibited the resident's ability to propel around the facility independently for 1 of 2 residents reviewed for accommodation of needs (Resident #4). The findings included	F 558	Resident #4 was issued a replacement standard wheelchair by the Housekeeping Director on 12/14/2022. A 100% audit of all in-house residents for accessibility to his/her wheelchair was completed on 12/20/2022 by Therapy Director and/or Designee. For any resident found to have a missing wheelchair, a replacement chair was issued by the Therapy Director and/or	1/12/23

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F 558	Continued From page 4 Resident #4 admitted to the facility on 04/05/16 with diagnoses that included end stage renal disease, hypotension, chronic pain, major depressive disorder, anxiety disorder, and type II diabetes mellitus. A review of Resident #4's quarterly Minimum Data Set assessment dated 10/04/22 revealed her to be cognitively intact with no behaviors, rejection of care, or instances of wandering. Resident #4 was coded as "activity did not occur" for locomotion on and off the unit and was coded with no use of physical restraints or alarms. Resident #4 was coded as receiving dialysis while a resident. During an interview with Resident #4 on 12/12/22 at 12:04 PM, she reported the facility had misplaced her wheelchair "a couple weeks ago" and she was not getting out of bed. She reported while her wheelchair was lost, the facility had gotten her up on a few occasions and placed her in a large reclining chair on wheels but that she could not move the chair so she would have to call for assistance when she wanted to move to another place in the facility. Resident #4 reported when she was in her regular wheelchair, she had the ability to mobilize around the facility on her own. She reported it became such a nuisance that after 3 or 4 times of getting up in the large reclining chair; she stopped asking to get out of bed at all. Resident #4 reported she had informed the Housekeeping Director of her missing wheelchair and he had attempted to locate it. During an interview with Nurse Aide (NA) #8 on 12/14/22 at 11:41 AM, she reported Resident #4 did not get out of bed a lot. She reported when Resident #4 did get out of bed, she had to be	F 558	Designee by 1/12/2023. A 100% in service for all staff was completed by 1/12/2023 by the Director of Nursing or designee on notifying the supervisor if resident wheelchair is missing so a replacement chair can be obtained. Any staff who did not receive this in-service by 1/12/2023 will not be able to work until this education is complete. This education was added to the new (hire) employee orientation packet on 12/27/2022 by the Administrator. The Director of Nursing or Designee will observe 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, and then 5 residents monthly for 1 month to ensure they have the appropriate wheelchair. The Director of Nursing or Designee will bring these audits to the Quality Assurance Committee x3 consecutive meetings, at which time, a determination will be made if further monitoring is necessary. Completion Date 1/12/2023	

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F 558	Continued From page 5	F 558		

placed in the large reclining chair on wheels that was kept in her room because her wheelchair had been misplaced. NA #4 verified that Resident #4 could not propel freely when in the large reclining chair on wheels like she could when she was in her own wheelchair.

During an interview with NA #7 on 12/14/22 at 12:18 PM, she reported Resident #4 did not get out of bed a lot. She stated with Resident #4's wheelchair missing, when she was gotten out of bed, she was placed in a large reclining chair on wheels. NA #7 reported when Resident #4 was in her regular wheelchair, she had the ability to propel herself around the facility and stated she did not believe Resident #4 would have the same ability when she was in the large reclining chair on wheels.

During an interview with the Housekeeping Director on 12/14/22 at 2:04 PM he reported he knew that Resident #4's wheelchair was missing. He also stated he had replaced her wheelchair with a replacement wheelchair but that one had went missing as well. He stated he could not remember how long Resident #4 had gone without a wheelchair while the other wheelchairs were missing. He reported while the missing wheelchairs were being located, Resident #4 was being placed in a large reclining chair on wheels when Resident #4 wanted to get up and out of bed.

During an interview with the Director of Nursing on 12/15/22 at 11:58 PM, she reported she did not know about Resident #4's missing wheelchair. She reported she would have wanted her staff to locate another wheelchair and provide it to Resident #4 as she was aware Resident #4

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F 558	Continued From page 6 would be unable to propel herself in the large reclining chair on wheels that facility staff had reported they placed her in. She stated she felt the facility had plenty of extra wheelchairs and did not understand why staff began placing Resident #4 in the large reclining chair on wheels. During an interview with the Administrator on 12/15/22 at 12:36 PM, she reported she was aware Resident #4's wheelchair had been misplaced. She also reported she would have preferred her staff find another wheelchair for Resident #4 to use while hers was misplaced instead of using the large reclining chair on wheels to put Resident #4 in since she would not be able to propel in it.	F 558		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to ensure a dependent resident received the assistance they required to complete activities of daily living resulting in long, dirty fingernails for 1 of 5 residents reviewed for Activities of Daily Living (ADL)(Resident #38). The findings included: 1. Resident #38 was admitted to the facility on 06/30/22 with diagnoses that include hemiplegia and hemiparesis follow a stroke, contracture to	F 677	On 12/14/22 Unit Manager cleaned, trimmed, and filed Resident #38□s fingernails. 100% audit of all in house residents was conducted on 12/15/2022 by Director of Nursing Services or Designee to ensure resident fingernails were clean and trimmed. No other issues were identified. The Director of Nursing or designee completed in-servicing to all nursing staff on nail care by 1/12/2023. Any nursing	1/12/23

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F 677	Continued From page 7 left hand, muscle weakness, and major depressive disorder. A review of Resident #38's quarterly Minimum Data Set Assessment dated 10/05/22 revealed Resident #38 to be cognitively intact with no psychosis, behaviors, or rejection of care. Resident #38 was coded as requiring extensive assistance with personal hygiene and was totally dependent with bathing. A review of Resident #38's care plan last revised on 10/19/22 revealed a care plan for "Resident requires assistance from staff for ADLs ...". Interventions included provide assistance with all ADLs including mobility and transfers as needed, being careful not to overwhelm resident. During an observation and interview with Resident #38 on 12/12/22 at 11:50 AM, she reported she had to "pitch a fit" to get her nails trimmed. Resident #38's fingernails were observed to be long, extending ½ to 1 inch past the tips of her fingers, with black matter caked underneath the nails. An additional observation made of Resident #38 on 12/13/22 at 1:03 PM, revealed resident to be eating her lunch meal that consisted of a hotdog on a bun with chili and French fries. Resident #38 was feeding herself with her right hand. Resident #38's nails continued to be ½ - 1 inch beyond the end of her fingers with black matter under all 5 nails on her right hand. During an interview with NA #7 on 12/14/22 at 12:12 PM, she reported nail care should be completed on shower days and as needed, unless the resident was diabetic; then a nurse	F 677	staff who did not receive this in-service by 1/12/2023 will not be able to work until this education is complete. This education was added to the new hire employee orientation packet on 12/27/2022 by the Administrator. The Director of Nursing or Designee will complete nail audits on 10 random residents weekly X 4 weeks, then 5 residents weekly X4 weeks, then 5 residents monthly X 1 month. The Director of Nursing or Designee will bring these audits to the Quality Assurance Committee x 3 consecutive meetings at which time a determination will be made if further monitoring is necessary. Completion Date 1/12/2023	

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F 677	Continued From page 8	F 677		

would be responsible for trimming a resident's nails. NA #7 also reported nails should be monitored on shower days, when passing trays, or when general care was being provided. She reported she had not seen Resident #38's nails and could not speak to their current condition.

During an interview with NA #8 on 12/14/22 at 1:42 PM, she reported she was familiar with Resident #38 and that she needed assistance with her ADLs. NA #8 reported she checked nails on shower and bathing days. She reported she last worked with Resident #38 on 12/11/22 and could not recall the condition of Resident #38's fingernails at that time.

During an interview with Nurse #3 on 12/14/22 at 2:48 PM she reported nail care was typically provided by the NAs on the hall unless the resident was diabetic, then the NAs would inform the nurse and the nurse would trim the nails. She reported that NAs were responsible for ensuring that nails were kept clean. Nurse #3 was shown the condition of Resident #38's fingernails at this time and she reported they needed to be cleaned and that they should not have been that dirty.

During an interview was completed with the Director of Nursing on 12/14/22 at 2:48 PM after she observed the condition of Resident #38's fingernails. She reported the condition of Resident #38's fingernails was unacceptable and since Resident #38 was not diabetic, it would be the responsibility of the NAs to ensure they were neatly trimmed and cleaned. She stated she was unaware of the condition of Resident #38's fingernails and reported she would ensure they were cleaned.

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F 677	Continued From page 9 During an interview with the Administrator on 12/15/22 at 12:36 PM, she reported she expected ADLs to be completed as required for each resident in the facility.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		1/12/23

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F 690	Continued From page 10 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to prevent a urinary catheter bag and tubing from touching the floor and failed to anchor the catheter tubing to prevent pulling and trauma for 1 of 2 residents (Resident #61) reviewed for urinary catheters. The findings included: Resident #61 was admitted to the facility on 10/19/22 with diagnoses that included neurogenic bladder. Review of Resident #61's care plan dated 11/01/22 indicated the Resident required a catheter due to neurogenic bladder. The goal to not experience no signs and symptoms of complications related to the use of the catheter would be attained by keeping the catheter free of kinks and keeping the catheter below the bladder. Review of Resident #61's physician orders dated 11/26/22 revealed, Secure (catheter) tubing with leg strap. The quarterly Minimum Data Set assessment dated 11/28/22 revealed Resident #61's cognition was severely impaired, and he had an indwelling urinary catheter. On 12/12/22 11:02 AM an observation was made of Resident #61 lying in bed with his urinary catheter bad tied to the left side of the bed frame by a string and the catheter tubing looped below	F 690	On 12/12/2022, Resident #61 urinary catheter bag was changed, secured to bed with tubing and bag off the floor and secured to the resident leg by the Unit Manager. A 100% audit of all in house residents with catheter bags was conducted on 12/20/2022 by Director of Nursing or Designee to identify any urinary catheter bag or tubing touching the floor or any resident with an urinary catheter that did not have a securing device to prevent trauma or pulling. No other residents affected by this deficient practice. The Director of Nursing or designee completed an in-service for all nursing staff on preventing urinary catheters and tubing from touching the floor and by ensuring all residents with urinary catheters had secure device to prevent tubing from causing trauma or pulling by 1/12/2023 Any staff who did not receive this in-service by 1/12/2023, will not be able to work until this education is complete. This education was added to the new (hire) employee orientation packet on 12/27/22 by the Administrator. The Director of Nursing or Designee will observe 5 residents urinary catheter bags to ensure the bag and tubing is not touching the floor and to ensure the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 11 the catheter bag and touching the floor. (Unable to determine if a catheter anchor was being used). During a second observation of Resident #61 on 12/12/22 2:51 PM the Resident's urinary catheter bag and the catheter tubing was touching the floor. On 12/12/22 2:52 PM Unit Manager (UM) #2 who also functioned at the Infection Preventionist walked into Resident #61's room and looked around the room then proceeded to converse with the roommate then walked back out of the room. At 2:54 PM on 12/12/22 the UM walked back into Resident #61's room and gave the Resident's roommate a snack then looked around the room again before she exited the room. During an interview with Nurse Aide (NA) #1 on 12/12/22 2:58 PM she confirmed that she was responsible for Resident #61 that shift. The NA acknowledged the catheter bag and tubing touching the floor and stated that the bag and tubing should be below the bladder but not touching the floor because it was a sanitary issue, and the Resident could develop a urinary tract infection. The NA was asked to determine if the Resident wore a stabilizing device for the catheter tubing and the NA looked for the device but there was no stabilizing device in use for the catheter tubing. The NA explained the Resident should be wearing a stabilizing device to prevent from pulling and causing trauma. The NA observed the catheter bag was tied to the bed frame with a string and stated the bag should have a hook to hang the bag and attempted to untie the string from the bed frame but could not untie the string	F 690	resident has a urinary catheter securing device to prevent trauma or pulling weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 5 residents monthly for 1 month. The Director of Nursing or Designee will bring these audits to the Quality Assurance Committee x 3 consecutive meetings, at which time, a determination will be made if further monitoring is necessary. Completion Date 1/12/2023	

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	345471	A. BUILDING _____ B. WING _____	C 12/15/2022

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F 690	Continued From page 12 and stated she needed to inform the UM #2 and laid the catheter bag back on the floor. An interview was conducted with Unit Manager #2 at 3:20 PM 12/12/22. The UM acknowledged the Resident's catheter bag and tubing were resting on the floor and there was no stabilizing device in place. The UM explained that all residents should wear an anchoring device to stabilize the catheter tubing to prevent trauma and the catheter bag and tubing should not be touching the floor for infection control purposes. She stated the Resident had a tendency to pick at things and could have removed the anchoring device himself. The UM replaced the catheter bag with a new one and taped an anchoring device to the Resident's thigh to prevent pulling and trauma. On 12/15/22 9:32 AM during an interview with the Interim Director of Nursing she explained that the catheter bag and tubing should never touch the floor for infection control purposes and the catheter tubing should be anchored to the residents' thighs as to not cause pulling and trauma. An interview was conducted with the Administrator on 12/15/22 10:48 AM. The Administrator indicated the residents who had urinary catheters should be monitored frequently to prevent the catheter bag and tubing from touching the floor and ensure the stabilizing device was utilized.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		1/12/23

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F 695	Continued From page 13 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to obtain a physician order for supplemental oxygen for 1 of 2 residents (Resident #37) reviewed for respiratory care. The finding included: A review of an undated standing order policy related to supplemental oxygen revealed "O2 @1-5 liters per minute (LPM) via nasal cannula (NC) as needed (PRN) to keep oxygen saturation >92%. If the patient needs oxygen longer than 24 hours physician (MD) order needed to continue." Resident #37 was admitted to the facility on 11/15/19 with diagnoses that included cerebral vascular accident. The quarterly Minimum Data Set (MDS) assessment dated 09/28/22 revealed Resident #37's cognition was severely impaired and was not coded for oxygen use. Review of Resident #37's care plan updated 09/28/22 revealed there was no care plan for supplemental oxygen. Review of Resident #37's physician orders revealed there was no order for supplemental	F 695	On 12/20/22, Resident #37 oxygen orders were ordered and entered by the Medical Director. A 100% audit of all in house residents on oxygen for oxygen orders was conducted on 12/20/22 by Director of Nursing or Designee. No other residents were affected. The Director of Nursing or designee completed an in-service on 1/12/2023 for all licensed nurses on entering oxygen orders for residents who require oxygen. Any Licensed nurse who did not receive this in-service by 1/12/2023, will not be able to work until this education is complete. This education was added to the new (hire) employee orientation packet on 12/27/22 by the Administrator. The Director of Nursing will observe 5 residents on oxygen weekly for 4 weeks and then 3 residents weekly for 4 weeks and then 5 residents monthly for 1 month. The Director of Nursing will bring these audits to the Quality Assurance Committee x 3 consecutive meetings, at which time, a determination will be made	

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F 695	Continued From page 14 oxygen. A review of Resident #37's Medication Administration Record (MAR) for 12/01/22 through 12/12/22 revealed there was no order for supplemental oxygen administration. A review of Resident #37's medical record on 12/12/22 7:48 AM revealed the oxygen saturation was 97%. On 12/12/22 12:39 PM during an observation of Resident #37 the Resident wore supplemental oxygen via nasal cannula at 4 liters per minute (l/min) via the oxygen concentrator. An observation of Resident #37 on 12/13/22 9:06 AM revealed the Resident received 3 l/min of supplemental oxygen via the nasal cannula by the oxygen concentrator. During an observation of Resident #37 on 12/14/22 3:45 PM the Resident received supplemental oxygen via nasal cannula at 3 l/min by the oxygen concentrator. An interview was conducted with Nurse #5 on 12/14/22 3:45 PM who explained that Resident #37 was sent to the hospital last week and came back from the hospital with continuous oxygen via nasal cannula at 3 l/min. The Nurse searched through the Resident's Medication Administrator Record and could not find the order for oxygen. The Nurse stated she knew the Resident was supposed to be on oxygen because she was the Nurse who readmitted her to the facility when she returned from the hospital and since she was new to the facility, she forgot to obtain an order for the oxygen from the physician.	F 695	if further monitoring is necessary. Completion Date 1/12/2023	

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F 695	Continued From page 15	F 695		

An interview with Nurse #6 conducted on 12/15/22 1:47 PM revealed the Nurse confirmed she worked with Resident #37 on 12/12/22 and 12/13/22. The Nurse explained that the Resident wore oxygen on the days she provided care vial nasal cannula at 2 l/min. The Nurse stated she should have noticed the oxygen order was not on the Resident's MAR and obtained the order for the oxygen.

An interview was conduced with Unit Manager (UM) #2 on 12/14/22 3:50 PM who explained that Resident #37 was sent to the hospital on 12/02/22 and returned to the facility on 12/05/22 with diagnosis of acute congestive heart failure and required supplemental oxygen via nasal cannula. The UM reviewed the Resident's readmission orders from the hospital and noted there was no order for supplemental oxygen included in the orders. The UM stated the admitting nurse should have noticed that there was no order for supplemental oxygen and obtained an order from the physician. The UM continued to explain that there were standing orders to administer oxygen for acute episodes but if the oxygen was needed to continue then they should obtain a physician's order for the oxygen.

On 12/15/22 at 9:20 AM an interview was conducted with the interim Director of Nursing (DON) who explained that the clinical managers made rounds every day and should have noticed that Resident #37 was on oxygen and followed through with obtaining the order for the oxygen.

During an interview with the Administrator on 12/15/22 10:42 AM she explained that the

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F 695	Continued From page 16 admitting nurse should have recognized that Resident #37 was on oxygen when she returned from the hospital and obtained a physician's order for the oxygen.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications and failed to date open insulin pens for 1 of 3 medication carts reviewed for medication storage	F 761	On 12/12/2022, expired medications and unlabeled insulin pens were removed from medication cart #2 and reordered from the pharmacy by the Unit Manager.	1/12/23

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F 761	Continued From page 17 (200 hall Medication Cart #2). The findings included: An observation of the 200 hall Medication Cart #2 was made on 12/12/22 at 3:30 PM along with Nurse #4. The observation revealed the following: - Advair Diskus (inhaled medication) 100 micrograms (mcg)/50 mcg that expired on November 30, 2022 and was opened on 12/10/22 and had 24 doses remaining. - Hyoscyamine (used to treat spasms) 0.125 milligrams (mg) 15 tablets that expired 11/22. - 2 Novolog insulin vials that were opened with no date of when they were opened and no pharmacy label to indicate when they had been sent to the facility. - Levemir Flex touch insulin pen that was opened with no date of when it was opened and no pharmacy label to indicate when it had been sent to the facility. Nurse #4 was interviewed on 12/12/22 at 3:35 PM and revealed that she only worked at the facility as needed and had not worked in the last two weeks until today (12/12/22). Nurse #4 stated she had not gone through her medication cart to determine if there were any expired medications and was not sure who was responsible for doing so. She also stated she could not tell when the insulin expired because there was no date when they were opened. Nurse #4 could not recall if they had been opened and on the medication cart two weeks ago when she worked. Nurse #4 stated she knew who her chain of command was and that Unit Manager (UM) #1 was her direct supervisor.	F 761	100% audit of medication carts and medication rooms was completed by Regional Clinical Manager on 12/12/2022 to ensure no other expired medications and unlabeled insulin pens were found. Any expired or unlabeled medications found were discarded on 12/12/2022 by Regional Clinical Manager. Director of Nursing or designee completed a 100% in-service for all licensed nurses and medication aides on labeling and storing medications, discarding medications based on expiration dates by 1/12/2023. Any licensed nurse or medication aide who did not receive this in-service by 1/12/2023, will not be able to work until this education is complete. This education was added to the new (hire) employee orientation packet on 12/27/22 by the Administrator. The Director of Nursing or Designee will audit medication carts and medication rooms to look for expired medications and unlabeled insulin pens 3 times weekly for 4 weeks and then weekly X 8 weeks. The Director of Nursing or Designee will bring these audits to the Quality Assurance Committee x 3 consecutive meetings, at which time, a determination will be made if further monitoring is necessary. Completion Date 1/12/2023	

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F 761	Continued From page 18 UM #1 was interviewed on 12/13/22 at 1:42 PM. UM #1 stated that she tried to go through the medication carts routinely, but night shift staff was also expected to go through the medication carts on a weekly basis and all expired or outdated medications should be removed and returned to the pharmacy. UM #1 stated that whoever opened the insulin vial or pen was responsible for dating it and then each medication cart had a sheet in the front of the book on their medication carts that told them how many days each type of insulin was good for. When the nurses were using the insulin, they should be checking the dates on the vial or pen to ensure that the insulin was still in date and if not, it should be discarded, and a new vial or pen obtained. The interim Director of Nursing (DON) was interviewed on 12/14/22 at 11:42 AM and confirmed that the night shift staff along with the UMs were expected to go through the medication carts and rooms at least weekly and discard any expired medication and any undated or outdated insulins pens/vials. These medications were to be discarded and new obtained.	F 761		