STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER SOUTHPOINT	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 were conducted from 12/18/22 through 1/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # J29W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/18/22 through 1/10/23. Event ID# J29W11. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity J Immediate Jeopardy began on 12/19/22 and was removed on 12/21/22. The following intake was investigated: NC00194219 2 of 2 complaint allegations were not substantiated. F697 was increased to a scope and severity of H during the deficiency review process which took place after the survey exit date. The increase in scope and severity resulted in the deficient practice being cited at Substandard Quality of care and required an extended survey. An extended survey was conducted on 1/10/23. The exit date of the survey was changed to 1/10/23.	F 000		
F 677 SS=E	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	F 677		2/10/23

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

Electronically Signed | 01/20/2023

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F 677	Continued From page 1 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews of staff and residents, the facility failed to provide dependent residents incontinence care for 3 of 6 residents reviewed for activities of daily living (Residents #75, #79, and #81). Findings included: 1. Resident #75 was admitted to the facility on 9/16/21 with the diagnosis of other fracture. Resident #75 had a physician order for Myrbetriq 25 milligrams every day for an overactive bladder. Resident #75's annual Minimum Data Set dated 10/21/22 documented the resident had an intact cognition and had a diagnosis of other fracture. The resident required extensive assistance of one staff member for personal care. The resident was always incontinent of urine and bowel. Resident #75's care plan updated for the annual review on 10/21/22 documented an activity of living self-care deficit and required assistance for personal care. On 2/19/22 at 9:00 am an observation was done of Resident #75. She was in bed and there was urine odor. Concurrent interview: Resident #75 stated she was wet and "this happens every morning where she was wet on day shift until breakfast trays were retrieved after 9 am." She stated she was changed on night shift at 6:00 am. She stated the day shift Nursing Assistants (NA) do not provide incontinence care from the start of breakfast tray pass until all residents are fed and trays are retrieved. "One morning I waited until 11:20 am to get changed (incontinence care)."	F 677	1. No residents were harmed as a result of this deficient practice. Resident #75, #79, and #81 incontinence care was immediately provided th those residents with no ill effects noted. 2. All residents have the potential to be affected by this deficient practice. All dependent residents for incontinence care were audited to ensure they were provided care in a timely manner, including during mealtimes. Nursing care accommodations will be made if incontinent care is required during mealtimes per their plan of care by DON/designee by the Infection Preventionist/designee on 12/21/22. All Nursing staff were in-serviced by the DON/designee on ensuring all residents that are dependent on staff to provide proper incontinence care on 12/21/22. 3. 10 CNAs will be audited while giving care to dependent residents to ensure they are receiving prompt incontinence care per their plan of care per the incontinent care policy. Accommodations will be made if incontinent care is required during mealtimes also, is given by Unit Manager/designee 3 times weekly times twelve weeks. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee monthly times three by the Director of Nursing/Administrator/designee to ensure	

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F 677	Continued From page 2	F 677		

Resident #75 stated, "if I placed my call light on for incontinence care during meal tray pass staff would respond and ask me to wait until after the meal. I wait more than 3 hours for care provided after breakfast (is wet when served meal while waiting). The waiting makes me angry."

On 12/19/22 at 9:40 am NA #4 was observed to enter Resident #75's room to provide incontinence and morning care. The resident's undergarment was full of yellow urine. The resident declined permission for surveyor observation of incontinence care and commented that her skin was intact. NA #4 initiated care according to her availability.

On 12/19/22 at 9:40 am an interview was conducted with NA #4. NA #4 stated she was the assigned NA on 12/19/22 for Resident #75. NA #4 stated she made safety rounds at the beginning of day shift around 7:15 am and had not provided Resident #75 any incontinence or personal care until now. She stated she does not provide incontinence care during safety rounds. She stated the residents were to receive incontinence care every 2 hours. She stated NAs were required to wait until meal trays were passed, residents were fed, and trays were retrieved before NAs could provide incontinence care. This was a facility requirement. The time for tray pass to tray retrieval could cause the time for incontinence care for some residents to be longer than 2 hours. NA #4 further stated, "If the Residents' placed their call light on, staff responded and asked the resident to wait until after meal trays were retrieved. Residents know that staff cannot assist with incontinence care during mealtime and wait until after the meal

solutions are sustained and to addrress any concerns.

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F 677	Continued From page 3	F 677		

when we can get to them." She further stated that she was responsible to provide care for all her assigned residents.

On 12/19/22 at 9:30 am an interview was conducted with NA #3. She stated that the NAs do not provide personal/incontinence care to the residents once the meal trays arrived until after the trays were retrieved. This requirement was a facility policy. She stated the nurses arrived at 7:00 am and rounds were started to check the residents and receive report. Care was started at shift change but cannot be completed by the time breakfast trays arrived at 8:00 am.

On 12/19/22 at 10:05 am an interview was conducted with Nurse #7 assigned to Hall #200. She stated that NA staff were required to refrain from incontinence care during meal tray pass through to meal tray retrieval. This included time feeding residents. The NA staff could ask nursing to assist during the meal if a resident had a bowel movement. She stated morning medication pass was busy and there was little time to assist with incontinence care and she had not received any resident complaints about incontinence care. She stated the NAs entered at 7:00 am, received report, and made safety rounds. After rounds, the NAs started incontinence care. The breakfast meal trays arrived at around 8:00 am so not all residents in an assignment could have received incontinence care before meal trays arrived. The residents who had not received care before breakfast would have to wait until the meal was over and trays were retrieved.

On 12/20/22 at 2:40 pm an interview was conducted with the Director of Nursing (DON). The DON stated that nursing assistant staff were

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F 677	Continued From page 4	F 677		

not permitted to provide incontinence care during meal tray pass to meal tray retrieval, that was facility policy. Licensed nursing staff could assist if requested but agreed morning medication pass on Hall 200 was heavy and would leave little time for the assigned nurse to provide incontinence care. The other medication pass times that coincide with the lunch and dinner meal tray pass were not as busy. The DON indicated that waiting for incontinence care was acceptable. The NAs were not permitted to provide incontinence care during mealtimes and there were no available Patient Care Assistants.

2. Resident #79 was admitted to the facility on 10/26/22 with the diagnosis of urinary tract infection and sepsis (infection of the blood).

Resident #79's admission Minimum Data Set dated 11/2/22 documented the resident had an intact cognition. Toilet use and personal care required extensive assistance of one person. The resident was frequently incontinent of urine and bowel.

Resident #79's care plan dated 11/2/22 documented the resident had an activity of daily living self-care performance deficit with an intervention to provide personal care. The resident was at risk for pressure ulcer development and had urine incontinence. The intervention was to check routinely for incontinence and provide assistance to the bathroom as needed.

Resident #79 had a physician order dated 10/27/22 for Lasix 20 mg each day (diuretic scheduled for 8:00 am).

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On 12/18/22 at 9:55 am an observation and interview were done with Resident #79. The resident was waiting for her first morning day shift urine incontinence change after breakfast meal tray pass and retrieval. Urine odor was present. The resident's brief was wet and full of yellow urine. During concurrent interview the resident indicated she had been wet shortly after being changed by night shift staff (approximately 6:00 am) and was not changed yet this morning (about 4 hours). The incontinence delay had been going on during mealtime (all meals). The resident commented that she does not request incontinence care during mealtime because the staff informed her, she had to wait until after the meal to receive care. The resident indicated she ate her meal while she was wet on 12/19/22.

On 12/19/22 at 9:40 am an interview was conducted with NA #4. NA #4 stated she was assigned to Resident #79 on 12/19/22. NA #4 stated she made safety rounds at the beginning of day shift around 7:15 am and had not provided Resident #79 any incontinence or personal care until now when I could get to her. She stated the residents were to receive incontinence care every 2 hours. She stated NAs were required to wait until meal trays were passed, residents were fed, and trays were retrieved before NAs could provide incontinence care. This was a facility requirement. The time for tray pass to tray retrieval could cause the time for incontinence care for some residents to be longer than 2 hours. NA #4 further stated, "If the Residents' placed their call light on, staff responded and asked the resident to wait until after meal trays were retrieved. Residents know that staff cannot assist with incontinence care during mealtime and wait until after the meal when we can get to

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them." She further stated that she was responsible to provide care for all her assigned residents.

On 12/18/22 at 10:20 am an observation was done of NA #4. NA #4 provided incontinence care for Resident #79. The resident's brief was full of yellow urine and strong odor was noted. Resident #79's skin was intact and there was no redness or irritation observed.

On 12/19/22 at 9:30 am an interview was conducted with NA #3. She stated that the NAs do not provide personal/incontinence care to the residents once the meal trays arrived until after the trays were retrieved. This requirement was a facility policy. She stated the nurses arrived at 7:00 am and rounds were started to check the residents and receive report. Care was started at shift change but cannot be completed by the time breakfast trays arrived at 8 am.

On 12/19/22 at 10:05 am an interview was conducted with Nurse #7 assigned to Hall #200. She stated that NA staff were required to refrain from incontinence care during meal tray pass through to meal tray retrieval. This included time feeding residents. The NA staff could ask nursing to assist during the meal if a resident had a bowel movement. She stated morning medication pass was busy and there was little time to assist with incontinence care and she had not received any resident complaints about incontinence care. She stated the NAs entered at 7:00 am, received report, and made safety rounds. After rounds, the NAs started incontinence care. The breakfast meal trays arrived at around 8:00 am so not all residents in an assignment could have received

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incontinence care before meal trays arrived. The residents who had not received care before breakfast would have to wait until the meal was over and trays were retrieved.

On 12/20/22 at 2:40 pm an interview was conducted with the Director of Nursing (DON). The DON stated that nursing assistant staff were not permitted to provide incontinence care during meal tray pass to meal tray retrieval, that was facility policy. Licensed nursing staff could assist if requested but agreed morning medication pass on Hall 200 was heavy and would leave little time for the assigned nurse to provide incontinence care. The other medication pass times that coincide with the lunch and dinner meal tray pass were not as busy. The DON indicated that waiting for incontinence care was acceptable. The NAs were not permitted to provide incontinence care during mealtimes and there were no available Patient Care Assistants.

3. Resident #81 was admitted to the facility on 6/6/22 with the diagnoses of muscle weakness, progressive neurological condition, and hemiplegia.

The quarterly Minimum Data Set dated 11/2/22 documented intact cognition. The resident required one-person physical assistance for personal hygiene and toileting. The diagnosis was progressive neurological condition. The resident was occasionally incontinent of urine.

Resident #81's care plan updated on 11/3/22 during Minimum Data Set (MDS) review documented an activity of daily living deficit related to neurological condition. The intervention was for staff to assist the resident as needed with

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personal hygiene. The resident was at risk for pressure ulcer and the goal was to have intact skin. The intervention was to provide incontinence care at each incontinence episode.

Resident #81 participated in an interview on 10/18/22 at 11:30 am. The resident stated she was not receiving assistance to the bathroom once the meal trays were passed until all trays were retrieved. An observation revealed that there was a urine odor and yellow urine in her brief. Resident #81 stated she did not want to be incontinent and sit in wet. "This seemed to be a problem during the breakfast mealtime. Staff were required to pass meal trays and wait until retrieval was completed before resuming toileting, personal care, and incontinence care." "The last toileting was just after 6:00 am by night staff. I require limited assistance. Sometimes the staff does not come because they know I had been able to get there on my own, even when I use the call light. I should be able to get assistance when I need it." The Resident stated "I typically wait for 3 or more hours until after the breakfast to receive assistance. When I asked staff for assistance during the meal, I am informed to wait until after meal trays are retrieved, so I just wait." The resident indicated that when she waits for care assistance during breakfast, she gets incontinent with urine and eats her breakfast wet.

On 12/19/22 at 9:40 am an interview was conducted with NA #4. NA #4 stated she was assigned to Resident #81 on 12/19/22. She completed safety rounds for the residents on her assignment and does not provide incontinence care during this time. She stated the residents were to receive incontinence care every 2 hours.

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F 677	Continued From page 9	F 677		

She stated NAs were required to wait until meal trays were passed, residents were fed, and trays were retrieved before NAs could provide incontinence care. This was a facility requirement. The time for tray pass to tray retrieval could cause the time for incontinence care for some residents to be longer than 2 hours. NA #4 further stated, "Residents know that staff cannot assist with incontinence care during mealtime and wait until after the meal when we can get to them." She further stated that she was responsible to provide care for all her assigned residents.

On 12/19/22 at 9:30 am an interview was conducted with NA #3. She stated that the NAs do not provide personal/incontinence care to the residents once the meal trays arrived until after the trays were retrieved. This requirement was a facility policy. She stated the nurses arrived at 7:00 am and rounds were started to check the residents and receive report. Care was started at shift change but cannot be completed by the time breakfast trays arrived at 8 am.

On 12/19/22 at 10:05 am an interview was conducted with Nurse #7 assigned to Hall #200. She stated that NA staff were required to refrain from incontinence care during meal tray pass through to meal tray retrieval. This included time feeding residents. The NA staff could ask nursing to assist during the meal if a resident had a bowel movement. She stated morning medication pass was busy and there was little time to assist with incontinence care and she had not received any resident complaints about incontinence care.

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F 677	Continued From page 10 She stated the NAs entered at 7:00 am, received report, and made safety rounds. After rounds, the NAs started incontinence care. The breakfast meal trays arrived at around 8:00 am so not all residents in an assignment could have received incontinence care before meal trays arrived. The residents who had not received care before breakfast would have to wait until the meal was over and trays were retrieved. On 12/20/22 at 2:40 pm an interview was conducted with the Director of Nursing (DON). The DON stated that nursing assistant staff were not permitted to provide incontinence care during meal tray pass to meal tray retrieval, that was facility policy. Licensed nursing staff could assist if requested but agreed morning medication pass on Hall 200 was heavy and would leave little time for the assigned nurse to provide incontinence care. The other medication pass times that coincide with the lunch and dinner meal tray pass were not as busy. The DON indicated that waiting for incontinence care was acceptable. The NAs were not permitted to provide incontinence care during mealtimes and there were no available Patient Care Assistants.	F 677		
F 697 SS=H	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident, staff, and Nurse Practitioner	F 697	1. Resident #206 pain medication was	2/10/23

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F 697	Continued From page 11 (NP) interviews, observations and record review, the facility failed to obtain and administer a controlled substance medication ordered to treat pain for a resident admitted with a recent fracture and surgical repair of her right lower leg. Failure to receive the pain medication over a 2-day period of time resulted in the resident experiencing pain rated up to "10" on a scale of 0 to 10 (with 10 representing the worst pain imaginable) resulting in nausea and a significant interference with her sleep. This occurred for 1 of 1 resident (Resident #206) reviewed for pain. The findings included Resident #206 was admitted to the facility on 12/7/22 from a hospital. Her cumulative diagnoses included chronic kidney disease and a recent motor vehicle accident resulting in a right leg bimalleolar fracture with surgical intervention. A bimalleolar fracture is an ankle fracture that involves both the tibia and fibula (the lower leg bones that end on either side of the ankle). The resident's 12/7/22 admission orders included the following, in part: --5% lidocaine patch (a topical pain medication) to be applied to the most painful area topically one time a day with removal of the patch as scheduled; --500 milligrams (mg) methocarbamol (a muscle relaxant) to be given as two tablets by mouth every 8 hours as needed for muscle spasms for 10 days; --325 mg acetaminophen to be given as two tablets by mouth three times a day for pain for 14 days (scheduled for 6:00 AM, 2:00 PM and 10:00 PM); --2 mg hydromorphone (an opioid pain reliever) to	F 697	received from the backup pharmacy STAT at 3:30pm on 12/19/22 and administered to resident prior to her appointment. Medication was available during resident's entire stay with an active order. 2. All residents that require prn pain medication have the potential to be affected by this deficient practice. DON/ADON audited residents with active orders for prn pain medication to ensure medications ordered by the MD are obtained, administered, documented and assessed (pain level) for effectiveness. Audit completed on 12/27/22 3. All nurses and agency/contract nurses were provided written inservice material and verbal instructions on Policy and Procedures for pain medication, narcotic ordering/re-ordering. Education included: notification of NP, PA, MD when a new hard script is required for refill, procedures for ordering/re-ordering narcotics after hours and on weekends. DON/ADON/Designee began inservices with written and verbal communication on 12/19/22 and completed on 12/22/22 with current staff/agency/contract staff. New staff members/agency/contract staff will receive written material and verbal communication on Policy and Procedure for pain medication, narcotic ordering/re-ordering prior to 1st shift worked and during new nurse orientation. DON/ADON/Designee will randomly audit 5 residents daily (to include weekends) for 12 weeks to ensure prn pain medication is ordered, obtained and administered.	

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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 697	Continued From page 12 be given as one tablet by mouth every 3 hours as needed (PRN) for moderate pain (rated 4-6). The resident's level of pain was rated on a scale of 0 to 10 with "0" indicative of no pain and "10" representing the worst pain imaginable). Hydromorphone is a controlled substance medication. --2 mg hydromorphone to be given as two tablets by mouth every 3 hours PRN for severe pain (rated 7-10); Documentation on Resident #206's December 2022 Medication Administration Record (MAR) indicated the resident received PRN hydromorphone as follows: --On 12/7/22, two doses of hydromorphone were documented as administered (one dose of one tablet and the second dose with two tablets); --On 12/8/22, one dose (two tablets) were documented as administered; --On 12/9/22, two doses (with two tablets each) of hydromorphone were documented as administered; --On 12/10/22, three doses (with two tablets each) of hydromorphone were documented as administered; --On 12/11/22, five doses (with two tablets each) of hydromorphone were documented as administered; --On 12/12/22, two doses (with two tablets each) of hydromorphone were documented as administered; --On 12/13/22, four doses (one dose with one tablet and three doses with two tablets each) of hydromorphone were documented as administered; --On 12/14/22, three doses (with two tablets each) of hydromorphone were documented as administered.	F 697	4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee monthly times three by the Director of Nursing/Administator/designee to ensure solutions are sustained and to address any concerns.	

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Resident #206's admission Minimum Data Set (MDS) dated 12/14/22 revealed she had intact cognitive skills for daily decision making. The resident required extensive assistance for all of her Activities of Daily Living (ADLs) with the exception of being independent with eating. The MDS assessment revealed she received scheduled and as needed (PRN) medications for almost constant pain making it hard to sleep at night and limiting her day-to-day activities. The resident rated the intensity of her pain as a "10." Resident #206 received an opioid pain medication on 7 out of 7 days during the look back period.

The resident's care plan included the following area of focus, in part:
--The resident has an alteration in musculoskeletal status related to fracture of the right ankle and status post-surgical intervention. (Date Initiated: 12/15/22). The planned interventions included provision of analgesics (pain medications) as ordered by the physician. Observe and document for side effects and effectiveness (Date Initiated: 12/15/22).

Documentation on Resident #206's December 2022 MAR indicated the resident received PRN hydromorphone as follows:
--On 12/15/22, two doses (with two tablets each) of hydromorphone were documented as administered to the resident;
--On 12/16/22, two doses (one with one tablet and the other with two tablets) of hydromorphone was documented as administered.

The resident's electronic medical record (EMR) and December 2022 Medication Administration

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Record (MAR) documented the following, in part:
--On 12/17/22 at 5:38 AM, Resident #206's level of pain was documented as a "6." The resident's MAR indicated she received 2 mg hydromorphone (2 tablets) at that time. Upon follow-up, the medication was reported to have been ineffective.
--On 12/17/22 at 11:23 AM, Resident #206's level of pain was documented as a "7." The resident's MAR indicated she received 2 mg hydromorphone (2 tablets) at that time. Upon follow-up, the medication was reported to have been ineffective.
--On 12/17/22 at 1:35 PM, her level of pain was documented as a "7."
--On 12/17/22 at 2:05 PM, her level of pain was documented as a "0."
--On 12/17/22 at 8:38 PM, Resident #206's level of pain was documented as a "8." The resident's MAR indicated she received 2 mg hydromorphone (2 tablets) at that time. Upon follow-up, the medication was reported to have been effective.

Resident #206's Controlled Medication Utilization Record (a declining inventory sheet) indicated the last dose of 2 mg hydromorphone dispensed for the resident was administered to her on 12/17/22 at 8:38 PM by Nurse #2.

An observation and interview was conducted on 12/18/22 at 11:50 AM with Resident #206 in the presence of a visitor. During the interview, the resident reported she received her last pain pill yesterday (12/17/22) and was hoping more of the medication would come in from the pharmacy today. However, she was told there may be "no more" until 12/19/22 or 12/20/22 due to the facility being unable to get a doctor's prescription for it.

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She reported having "constant" pain "all over" due to a serious car accident. When asked, the resident rated her pain level as a "7" on a scale of 0-10. She reported the pain was so intense she felt nauseated (but has not vomited). Resident #206 reported she was receiving acetaminophen and a pain patch. She stated these medications helped "a little bit." Observations made throughout the interview revealed Resident #206 did not exhibit any obvious signs of pain.

An interview was conducted on 12/19/22 at 1:20 PM with Nurse Aide (NA) #1. NA #1 was assigned to care for Resident #206 on first shift of 12/19/22. During the interview, the NA was asked if the resident had made her aware she was having pain. The NA stated Resident #206 had not complained of pain to her so far today, but noted the resident was a very positive and upbeat person. The NA recalled she had worked from 7:00 AM to 11:00 PM on 12/17/22 this past weekend. She recalled the resident did complain of pain on 12/17/22, particularly after the evening meal. When asked, the NA stated she always reported residents' complaints of pain to the hall nurse.

An interview was conducted on 12/19/22 at 1:30 PM with Nurse #2. Nurse #2 was assigned to care for the resident on first shift of 12/19/22. This nurse was also identified as being assigned to care for Resident #206 when she worked first shift on 12/17/22 and 12/18/22. When asked why hydromorphone was not available for administration to the resident on an as needed basis, the nurse reported she did not work at the facility on Friday. If she had worked, Nurse #2 stated she would have let the medical doctor (MD) or nurse practitioner (NP) know the resident

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was running low on her hydromorphone and obtained a written prescription to ensure this medication could be re-dispensed from the pharmacy and made available for the resident. Nurse #2 confirmed the resident was out of the hydromorphone yesterday (12/18/22). The nurse reported she tried to call the on-call MD but this MD wasn't comfortable writing a controlled substance script for someone he/she had not assessed. Nurse #2 stated she encouraged the resident to utilize alternative means of pain management (such as reading).

Unsuccessful attempts were made to contact NA #5. NA #5 was the nurse aide assigned to care for Resident #206 on second shift of 12/18/22.

A telephone interview was conducted on 12/20/22 at 8:33 PM with Nurse #5. Nurse #5 was identified as the hall nurse who was assigned to care for Resident #206 on second shift of 12/18/22. During the interview, the nurse recalled when she came in for her shift she was told the resident's hydromorphone had been ordered but had not come in yet. The nurse reported the resident did complain of pain and stated, "She was in a lot of pain." Nurse #5 stated at first the resident was "not happy" about the PRN pain medication not being available. She was given her scheduled pain medication (acetaminophen) and offered ice for her fractured ankle. The nurse stated she apologized to the resident and tried to talk her through the pain. When her shift was over at 11:00 PM, the resident appeared to have fallen asleep.

A telephone interview was conducted with NA #2 on 12/21/22 at 7:58 AM. NA #2 was identified as having cared for Resident #206 on third shift of

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12/18/22. During the interview, inquiry was made as to whether the resident told the NA she was in pain. The NA reported when he came in at 11:00 AM and made his initial rounds, the resident was working on her laptop. He recalled the resident requested an extra box of tissues from him, telling him she had been crying due to her pain. Resident #206 also told him the facility ran out of her pain medication and she didn't understand why. The NA reported he told the hall nurse about the resident's pain, the nurse gave the resident a scheduled medication, and about 3 hours later the resident reported she felt "some better."

A telephone interview was conducted on 12/20/22 at 9:46 PM with Nurse #6. Nurse #6 was identified as the hall nurse who was assigned to care for Resident #206 on third shift of 12/18/22. When asked about whether the resident reported having pain during her shift, the nurse reported, "She did have pain ....pain med wasn't there." She stated the resident told her that she had been hurting all day and her pain medication wasn't there. The nurse stated Resident #206 received the acetaminophen scheduled for pain management but reiterated her hydromorphone was not available. Nurse #6 added that the acetaminophen seemed to help and the resident did eventually go to sleep. When asked what she would typically do if a resident was out of a controlled substance medication, Nurse #6 reported it was usually difficult to get any controlled substances sent out to the facility because it was unlikely a prescription could be obtained from a provider during the third shift.

The resident's EMR and December 2022 MAR documented the following, in part:

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--On 12/18/22 at 6:00 AM, her level of pain was documented as a "0";
--On 12/18/22 at 1:27 PM, her level of pain was documented as a "0";
--On 12/18/22 at 10:12 PM, her level of pain was documented as a "6";
--On 12/18/22 at 10:35 PM, her level of pain was documented as a "0".
Resident #206's December MAR indicated no doses of hydromorphone were administered to the resident on 12/18/22.

An observation and interview was conducted on 12/19/22 at 8:10 AM with Resident #206. During the interview, the resident was asked if her hydromorphone had come in to the facility yesterday as she had hoped. She stated it did not. The resident reported she had excruciating pain (rated as a "10" at times) which "came and went" throughout the night. Resident #206 stated she had a hard time getting to sleep but finally did fall asleep for a little while. The resident stated at one point she "almost called 911" but wasn't sure what she could say because she was already in a rehab facility. The resident was hoping her pain medication would come in today. The resident was not observed to exhibit any obvious signs of discomfort or pain during the interview.

A follow-up interview was conducted with the resident on 12/19/22 at 1:05 PM. During the interview, the resident reported she had not received any hydromorphone but was told it would probably come in today. When asked about her level of pain and whether she told nursing staff she was still in pain, the resident reported she didn't think anyone had asked her to put a number on her level of pain either in the night or thus far today. She stated, "Everybody

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knows I'm in pain."

An interview was conducted on 12/19/22 at 1:30 PM with Nurse #2. Nurse #2 was assigned to care for Resident #206 on first shift of 12/19/22. The nurse reported this morning (12/19/22) she did obtain a prescription for the resident's hydromorphone, called the pharmacy, and requested the medication be sent out "stat" (as soon as possible). She expected the hydromorphone to be delivered to the facility this afternoon around 3:30 PM. During the interview, the nurse added that she had just given the resident "her scheduled pain medication." When asked, Nurse #2 confirmed the scheduled pain medication was acetaminophen.

An interview was conducted on 12/19/22 at 1:40 PM with the facility's Director of Nursing (DON). During the interview, the DON reported newly admitted residents who had a controlled substance ordered would typically come in to the facility with a prescription (script) for the medication or the facility's MD/NP could write one. Once a script was obtained, the facility would send it to the pharmacy and the pharmacy would dispense the medication. She reported staff tried to make requests for medications to the pharmacy by 5:00 PM each day so the med could be delivered on the pharmacy's next run to the facility at 11:30 PM. Since controlled substance medications were not kept in the facility's Omnicell (an automated medication dispensing system), other alternate means of acquiring the medication needed to be used. She reported either the facility's back-up pharmacy could be utilized or they could call their contracted pharmacy to "stat out" the medication. If a med was requested after 5:30 PM, it could be

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delivered from the pharmacy on the following run at 3:30 - 4:00 AM. She reported a third pharmacy delivery run was made each afternoon at around 3:30 - 4:00 PM. During the interview, the DON was informed of the situation encountered by Resident #206 on the weekend when she ran out of her PRN hydromorphone. The DON stated she had not been made aware of the situation. She reported the facility's Associate Medical Director was typically available (on-call any hours and weekends) and could have potentially sent a script electronically to the pharmacy to meet a resident's need for a controlled substance medication. The DON reported she would have expected the MD/NP to have been notified of the need to write a new script for a controlled substance pain medication 1-2 days before the resident ran out of the med so there would have been time to get the script and send it on to the pharmacy to be filled. A follow-up interview was conducted with the DON on 12/19/22 at 2:35 PM. At that time, the DON stated if Resident #206 had asked for her PRN pain medication when it was not available, she would have wanted to have been notified of the situation.

The resident's EMR and December 2022 MAR documented the following, in part:
--On 12/19/22 at 5:38 AM, her level of pain was documented as a "6";
--On 12/19/22 at 11:23 AM, her level of pain was documented as a "7";
--On 12/19/22 at 1:35 PM, her level of pain was documented as a "7";

A follow-up interview was conducted on 12/19/22 at 2:45 PM with Nurse #2. Nurse #2 reported the resident's hydromorphone was delivered earlier that afternoon.

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Resident #206's Controlled Medication Utilization Record indicated the first dose of 2 mg hydromorphone dispensed from the pharmacy on 12/19/22 was administered to the resident on 12/19/22 at 2:04 PM by Nurse #2 (representing a period of more than 41 hours since the last dose of hydromorphone had been administered).

A Provider Note authored by the facility's NP was dated 12/19/22 at 3:42 PM. The NP noted at the time of her visit, Resident #206 was on her way to therapy and she was "glad to have therapy today. Reports visitors over the weekend." At that time, the resident was reported to have acute post-operative pain. A notation was made by the NP to indicate the resident agreed to begin weaning herself off of the pain medications, as tolerated. The plan included increasing her scheduled acetaminophen to 3 - 325 mg tablets (975 mg three times daily) with 2 mg to 4 mg hydromorphone given every 4 hours PRN moderate to severe pain. A notation was also made to indicate non-steroidal anti-inflammatory drugs (NSAIDS) needed to be avoided for pain management due to the resident's history of chronic kidney disease.

A physician's order was received for the following medications on 12/19/22:
--325 mg acetaminophen to be given as 3 tablets by mouth three times a day for pain (scheduled for 6:00 AM, 2:00 PM and 10:00 PM).
--2 mg hydromorphone to be given as one tablet by mouth every 4 hours as needed for moderate pain (rated 4-6);
--2 mg hydromorphone to be given as two tablets by mouth every 4 hours as needed for severe pain (rated 7-10).

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F 697	Continued From page 22 An interview was conducted on 12/20/22 at 1:15 PM with the resident. During the interview, the resident confirmed she received her first dose of hydromorphone yesterday (12/19/22) around 2:00 PM prior to leaving for an appointment at the orthopedic clinic. Resident #206 stated she was very pleased the medication came in to the facility in time for her trip to the MD. A Provider Note authored by the facility's NP was dated 12/20/22 at 2:22 PM. At that time, the resident reported Resident #206's pain was controlled and she was trying to only take the hydromorphone when she really needed it. An interview was conducted on 12/21/22 at 10:15 AM with the facility's NP regarding Resident #206's pain management. The NP reported she had seen the resident on the morning of 12/19/22. At the time of her visit, the NP stated an electronic prescription for the hydromorphone had already been sent to the pharmacy with a request to "stat" it out to the facility for her. The NP reported Resident #206 became tearful as she told the NP that she had experienced a lot of pain over the last couple of days without the hydromorphone. The NP also reported when she followed up with the resident yesterday (on 12/20/22), she was doing fine with the pain management currently in place.	F 697		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		2/10/23

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F 732	Continued From page 23 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and record review and interview of staff, the facility failed to have the current, required nurse staffing information posted for 4 of 4 days reviewed.	F 732	1. No resident or staff were harmed as a result of this deficient practice. The Nursing daily staffing sheets are to be accurate, posted daily to have current required nurse staffing information.	

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F 732	Continued From page 24 Findings included: On 12/18/22 9:30 am during initial tour it was observed that both Nursing Units 1 and 2 had the information posted dated 11/29/22 on 12/18/22. During an observation on 12/19/22 at 11:12 am nurse staffing information posted at Nursing Station #1 was dated 12/18/22. On 12/20/22 at 9:40 am observation revealed the nurse staffing information posted at Nursing Station #1 was dated 12/19/22. During an observation on 12/21/22 at 11:27 am nurse staffing information posted at Nursing Station #1 was dated 12/20/22. On 12/21/22 at 11:50 am an interview was conducted with the Director of Nursing (DON). The DON stated she was not aware that the nurse staffing information was not posted for the current date and would follow up with the scheduler. The DON follow-up interview at 2:40 pm revealed the scheduler had not regularly posted the current nurse staff hours.	F 732	Immediately corrected on 12/21/22 by placing an updated nursing staffing sheet in a visible location at the main entrance, and at all 3 Nursing stations for residents and visitors to review. The format is clear and readable and placed in a prominent location. 2. All staff and contract agency staff and residents have the potential to be affected by this deficient practice. Nursing scheduler/designee to ensure the daily nursing staffing sheets are current, and accurate with the daily nursing staffing information and posted in visible locations in the center. Completed by the DON on 12/21/22. 3. Scheduling staff were in-serviced on daily nursing staffing posting requirements, public access to these nursing sheets, and the need to have current, required nurse staffing information posted daily. DON/ADON/designedd by 12/21/22. This will be audited 5 times a week all shifts for twelve weeks to ensure nurse staffing posting requirements are met. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee monthly times three by the Director of Nursing/Administrator/designee to ensure solutions are sustained and to address any concerns.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		2/10/23

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F 755	Continued From page 25 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 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 staff and Nurse Practitioner (NP) interviews and record reviews, the facility failed to consistently follow established procedures for the accurate accounting of controlled substance medications administered to 2 of 2 residents reviewed (Resident #206 and Resident #198) who received a controlled substance pain	F 755	1. No residents were harmed as a result of this deficient practice. Resident #206 and #198 suffered no ill effects by nursing not consistently following established procedures for the accurate accounting of controlled substance medication on a prn basis. This was confirmed by the DON on	

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F 755	Continued From page 26 medication on an as needed (PRN) basis. The findings included: 1. Resident #206 was admitted to the facility on 12/7/22. A review of the resident's admission orders dated 12/7/22 included 2 milligrams (mg) hydromorphone to be given as one tablet by mouth every 3 hours as needed (PRN) for moderate pain (rated 4-6); and 2 mg hydromorphone to be given as two tablets by mouth every 3 hours PRN for severe pain (rated 7-10) Hydromorphone is an opioid pain medication (a controlled substance). A review was conducted of Resident #206's December 2022 Medication Administration Record (MAR) and Controlled Medication Utilization Record (a declining inventory sheet) for the 2 mg hydromorphone tablets dispensed from the pharmacy for this resident. A comparison of the two documents identified the following discrepancies: --On 12/7/22 at 4:03 PM, one tablet of hydromorphone was documented on the MAR as having been administered to the resident by Nurse #4. However, this dose of hydromorphone was not documented as having been removed from the inventory on the Controlled Medication Utilization Record. --On 12/13/22 at 11:48 AM, one tablet of hydromorphone was documented on the MAR as having been administered to the resident by Nurse #2. However, the Controlled Medication Utilization Record indicated two tablets were pulled from the inventory for administration to Resident #206 on 12/13/22 at 11:48 AM. --On 12/14/22 at 1:31 PM, two tablets of hydromorphone were documented on the	F 755	12/21/22. 2. All Residents that require prn narcotic pain medication have a potential to be affected by this deficient practice. 100% house audit was completed by the DON to ensure nursing signed the controlled substance medication out on the controlled utilization record, and when medication is administered, the medication administration is documented on the MAR. If any discrepancies were noted, they were corrected immediately with education provided to the specific nurse staff member. 3. All staff and agency/staff were provided written material and verbal instruction on the policy and procedure for proper documentation for prn pain medication administration on the controlled substance record and on the MAR. DON/ADON/Designee began inservices on 12/21/22 through 12/27/22 to current staff/agency/contracted nurses. New staff/agency/contract nurses will receive written material and verbal communication on the Policy and Procedure of proper documentation for prn pain medication. Education will take place before the 1st shift worked and during the new nurse orientation. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Imporovement Committee monthly times three by the Director of Nursing/Administrator/designee to ensure solutions are sustained and to address any concerns.	

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Controlled Medication Utilization Record as having been removed from the inventory by Nurse #2. However, this dose of hydromorphone was not documented as administered to the resident on the MAR.
--On 12/15/22 at 8:00 AM, two tablets of hydromorphone were documented on the Controlled Medication Utilization Record as having been removed from the inventory by Nurse #2. However, this dose of hydromorphone was not documented as administered to the resident on the MAR.
--On 12/16/22 at 1:15 PM, one tablet of hydromorphone was documented on the MAR as having been administered to the resident by Nurse #9. However, the Controlled Medication Utilization Record indicated two tablets were pulled from the inventory for administration to Resident #206 on 12/16/22 at 1:19 PM.

A telephone interview was conducted on 12/20/22 at 8:16 PM with Nurse #4. When asked about the discrepancy between the documentation on the MAR and the Controlled Medication Utilization Record for this resident, the nurse stated she was sometimes pulled away from the med cart before she could complete her documentation. Nurse #4 reported at the end of her shift, she always checked her controlled substance medications to make sure the inventory count was correct.

A telephone interview was conducted on 12/21/22 at 9:12 AM with Nurse #2. Upon inquiry, the nurse described the process she typically followed to administer a PRN controlled substance pain medication to a resident. The nurse reported she would evaluate the resident and his/her level of pain, go to the resident's electronic medical record to see if a pain

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medication was ordered for the resident and to check if it was within the time parameters as to when it could be given. If the med was not yet due, she would go to the resident and explain the situation. She would also offer possible non-pharmacological alternatives to treat the pain, if available. When asked about when she would document that a medication was given, the nurse reported she would sign both the MAR and the Controlled Medication Utilization Record after the medication was administered to the resident. When asked about discrepancies noted between the residents' MARs and Controlled Medication Utilization Records, the nurse stated she possibly had interruptions while passing medications. She noted interruptions were especially a concern on the Rehabilitation unit she was frequently assigned to work on.

An interview was conducted with the Director of Nursing (DON) on 12/21/22 at 12:58 PM. During the interview, the discrepancies between residents' MARs and the Controlled Medication Utilization Records for controlled substance medications were discussed. Upon inquiry, the DON reported she would expect nursing staff to sign a controlled substance medication out on the Controlled Medication Utilization Record as soon as the med was pulled from the med cart. She reported as soon as the medication was administered to the resident, this med administration should be documented on the MAR.

An interview was conducted on 12/21/22 at 10:15 AM with the facility's Nurse Practitioner (NP) regarding pain management. During the interview, the NP reported she would review a resident's MAR to see how often a resident was

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administered a PRN controlled substance pain medication, for example. When asked, the NP reiterated she depended on the resident's MAR to provide this information and never reviewed the Controlled Medication Utilization Records. The NP reported that from her understanding, these two records should be consistent with one another and contain the same information.

2. Resident #198 was admitted to the facility on 12/16/22. A review of the resident's admission orders dated 12/16/22 included 5 milligrams (mg) oxycodone to be given as one tablet by mouth every 4 hours as needed for moderate pain (4-6) for 5 days; and 5 mg oxycodone to be given as two tablets by mouth every 4 hours as needed for severe pain (7-10) for 5 days. Oxycodone is an opioid pain medication (a controlled substance).

A review was conducted of Resident #198's December 2022 Medication Administration Record (MAR) and Controlled Medication Utilization Record (a declining inventory sheet) for the 5 mg oxycodone tablets dispensed from the pharmacy for this resident. A comparison of the two documents identified the following discrepancy:
--On 12/18/22 at 2:45 PM, two tablets of oxycodone were documented on the Controlled Medication Utilization Record as having been removed from the inventory by Nurse #2. However, this dose of oxycodone was not documented as administered to the resident on the MAR.

A telephone interview was conducted on 12/21/22 at 9:12 AM with Nurse #2. Upon inquiry, the nurse described the process she typically followed to administer a PRN controlled

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substance pain medication to a resident. The nurse reported she would evaluate the resident and his/her level of pain, go to the resident's electronic medical record to see if a pain medication was ordered for the resident and to check if it was within the time parameters as to when it could be given. If the med was not yet due, she would go to the resident and explain the situation. She would also offer possible non-pharmacological alternatives to treat the pain, if available. When asked about when she would document that a medication was given, the nurse reported she would sign both the MAR and the Controlled Medication Utilization Record after the medication was administered to the resident. When asked about discrepancies noted between the residents' MARs and Controlled Medication Utilization Records, the nurse stated she possibly had interruptions while passing medications. She noted interruptions were especially a concern on the Rehabilitation unit she was frequently assigned to work on.

An interview was conducted with the Director of Nursing (DON) on 12/21/22 at 12:58 PM. During the interview, the discrepancies between residents' MARs and the Controlled Medication Utilization Records for controlled substance medications were discussed. Upon inquiry, the DON reported she would expect nursing staff to sign a controlled substance medication out on the Controlled Medication Utilization Record as soon as the med was pulled from the med cart. She reported as soon as the medication was administered to the resident, this med administration should be documented on the MAR.

An interview was conducted on 12/21/22 at 10:15

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F 755	Continued From page 31 AM with the facility's Nurse Practitioner (NP) regarding pain management. During the interview, the NP reported she would review a resident's MAR to see how often a resident was administered a PRN controlled substance pain medication, for example. When asked, the NP reiterated she depended on the resident's MAR to provide this information and never reviewed the Controlled Medication Utilization Records. The NP reported that from her understanding, these two records should be consistent with one another and contain the same information.	F 755		
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	F 761		2/10/23

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F 761	Continued From page 32 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to: 1) Discard expired medications, loose capsules from an opened stock bottle of medication and one unidentified tablet lying on the bottom of a medication (med) cart drawer; and 2) Store medications in accordance with the manufacturer's storage instructions. This was occurred for 2 of 3 medication carts observed (Station 2 A/B Med Cart and Station 1 Med Cart). The findings included: 1-a. A medication storage observation was completed of the Station 2 A/B Med Cart on 12/19/22 at 11:20 AM with Nurse #3. The observation revealed 20 single dose vials of 5 milligrams (mg) / 1 milliliter (ml) haloperidol (an injectable formulation of an antipsychotic medication) dispensed by the pharmacy for Resident #6 were stored on the med cart. Each vial was labeled with a manufacturer expiration date of 11/22 (November 2022). Upon review of the manufacturer's labeling, Nurse #3 confirmed the vials of haloperidol were expired. The nurse was observed as she removed the expired vials from the med cart. An interview was conducted with the facility's Director of Nursing (DON) on 12/21/22 at 12:58 PM. During the interview, the DON reported she would have expected nursing staff to have checked the expiration date on the vials of haloperidol and removed them from the med cart when they were expired.	F 761	1. No residents were harmed as a result of this deficient practice. The facility failed to discard expired medications, loose capsules from an opened stock bottle of medication and one unidentified tablet lying on the bottom of a medication cart drawer. The facility did not store medications in the accordance with the manufacturer's storage instructions. The expired items identified were discarded immediately and all eye drops were placed in the upright position. 2. All residents have the potential to be affected by this deficient practice. All 7 medication carts were audited on 12/22/22. 100% medication cart audits were completed by the DON/ADON/Unit Manager/designee and any concerns noted with labeling/storage of medications within the medication cart was immediaely corrected for all 7 medication carts. 3. All staff and agency/contract nurses were provided written material and verbal communication on the Policy and Procedure for medication cart use, labeling/storage of medications, removal of expired medications and manufacture guidelines for storage of eye medications. All medication carts were provided with a customized storage compartment to store eye medications in an upright position per manufacture’s guidelines. DON/ADON/Designee began inservices on 12/21/22 through 12/27/22 to current staff/agency/contracted nurses. New	

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F 761	Continued From page 33 1-b. A medication storage observation was completed of the Station 2 A/B Med Cart on 12/19/22 at 11:20 AM with Nurse #3. The observation revealed an opened and uncapped stock bottle of 500 milligrams (mg) acetaminophen gel capsules was observed to be stored on its side in the top drawer of the med cart. Eight (8) acetaminophen gel capsules and one round pink tablet (not identified) were lying in the bottom of the med cart drawer. Upon review, Nurse #3 reported the loose gel capsules, tablet, and opened / uncapped stock bottle of acetaminophen needed to be discarded. An interview was conducted with the facility's Director of Nursing (DON) on 12/21/22 at 12:58 PM. During the interview, the DON reported Nurse #3 did the correct thing by discarding the stock bottle, the loose capsules and unidentified tablet. 2. Accompanied by Nurse #2, an observation was made on 12/19/22 at 11:00 AM of the Station 1 Med Cart 1. The observation revealed an opened bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) dispensed for Resident #58 was stored lying down on its side in the top drawer of the medication cart. A yellow auxiliary sticker placed on the bottle by the pharmacy read in part, " ...Store Upright." Review of the manufacturer's storage instructions for 1% prednisolone ophthalmic suspension included the following notation in part, "Store Upright." A review of Resident #58's physician orders and	F 761	staff/agency/contract nurses will receive written material and verbal communication on the Policy and Procedure for medication cart use, labeling/storage of medications, removal of expired medications and manufacture guidelines for storage of eye medications Education will take place before the 1st shift worked and during the new nurse orientation. DON/ADON/Designee will audit all medication carts weekly x 12 weeks to ensure all expired medications are removed, no loose medications and eye medications are stored per manufacturers guidelines. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee monthly times three by the Director of Nursing/Administrator/designee to ensure solutions are sustained and to address any concerns.	

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F 761	Continued From page 34 December 2022 Medication Administration Record (MAR) revealed the resident had a current order for 1% prednisolone ophthalmic suspension to be administered as one drop instilled into both eyes every 12 hours. An interview was conducted on 12/19/22 at 11:37 AM with Nurse #2. During the interview, the nurse was shown the labeling on the eye drop bottle containing the prednisolone ophthalmic suspension. Upon inquiry, the nurse reported she was previously unaware of these storage instructions. An interview was conducted with the facility's Director of Nursing (DON) on 12/21/22 at 12:58 PM. During the interview, the DON reported the nursing staff needed to look closer at the medication labeling for storage instructions.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		2/10/23

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F 812	Continued From page 35 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills from the dry ingredient bins during two kitchen observations. The facility failed to clean the floor and ceiling vents located over the food prep and food service area. This practice had the potential to affect food served to all residents. The findings included: During a kitchen tour on 12/18/22 at 10:00 AM, the following observations were made with the kitchen Cook: a. The 9- stove burners had a heavy grease build up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills. b. The 4-compartment ovens had a heavy grease buildup, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where foods were being cooked. There was a dried grease buildup was observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven.	F 812	1. No residents were harmed as a result of this deficient practie. The facility failed to keep good food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and or dried spills from the dry ingredient bins during 2 kitchen observations. The Dietary Manager, Dietary Manager Assistant, and Regional Dietician immediately corrected the observations noted on 12/21/22. 2. All residents have the potential to be affected by this deficient practice. A whole kitchen inspection was audited on 12/21/22 to ensure proper food procurement, food storage, food preparation and sanitary conditions. This was completed by the Dietary manager/designee. 3. All Dietary staff/contract staff were educated on proper food procurement, food storage, food preparation and sanitary conditions, policies, and procedures by 12/27/22. A 3 times a week audit of the kitchen will be completed to ensure proper food procurement, food storage, food preparation and sanitary conditions. This will be completed by the Dietary Manager/designee 3 times a week times twelve weeks. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance	

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F 812	Continued From page 36 c. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. In addition, the fryer had heavy grease and food build up inside and outside, food products behind the fryer. e. The 6 compartment steam tables had large volumes of dried food and liquid matter encrusted on the edges inside/outside. In addition, the steam table also had left over food in standing water, the pans were heavy encrusted with brown matter and burnt food items. f. The 2 plate warmers had 2 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around. g. The floor underneath the stove, fryer, steamer, and ovens had large amount of dried food, grease puddles and trash. h. The 6 ceiling vents and air conditions unit had large volumes of black dust/debris blowing over food service and prep surfaces. i. The 4 dry ingredient containers of sugar, flour, powder sugar and brown sugar, had dried food liquid build up inside/outside of the container. j. The 3-compartment insulated plate base warmer had 3 rows of clean base stored in the warmer. The inside had dried liquid spills and food particles inside and outside. The inside also had old food crumbs all around. K. The steamer had dried brown/yellow liquid matter encrusted on the edges inside and outside. In addition, the steamer had heavy grease and food buildup inside and outside, food	F 812	Performance Improvement Committee monthly times three by the Director of Nursing/Administrator/designee to ensure solutions are sustained and to address any concerns.	

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F 812	Continued From page 37	F 812		

products on the walls behind the steamer.
An observation was conducted on 12/18/22 at 10:04 AM, the Dietary Aide (DA) placed 2 rows of clean plates in the plate warmer and 3 rows of clean plate base into the base warmer. When asked when the last time was the plate and base warmer had been cleaned the response was "I don't know, and I am not sure if there was a cleaning checklist".
An interview was conducted on 12/18/22 at 10:15 AM, the Cook stated there was a cleaning checklist, but the DM kept that information in the office. She further stated she was unaware of when the kitchen equipment was last cleaned.

Follow-up observation on 12/21/22 at 11:30 AM, the following observations were made of the identified kitchen equipment, ceiling vents and air condition remained the same as the initial tour on 12/18/22, some areas have been worked on but not yet complete.

An interview was conducted on 12/21/22 at 11:45 AM, the Dietary Manager (DM), Dietary Manager Assistant (DMA) and Regional Dietician stated the kitchen staff were required to wipe down kitchen equipment after each meal and deep cleaned weekly in accordance with the kitchen cleaning checklist. The DM and DMA further stated they were responsible for ensuring the kitchen staff kept the equipment clean and orderly. The DM, DMA and Regional DM acknowledged the identified kitchen equipment, ceiling fan and air condition units had not been cleaned in several months. The DM stated all cleaning checklist and responsibilities were posted and available for all kitchen staff.

An interview was conducted on 12/21/22 at 12:24

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F 812	Continued From page 38 PM, the Administrator stated the Dietary Manager and Kitchen Supervisor was responsible for ensuring the kitchen was cleaned and maintained. The expectation would be for the Dietary Manager to ensure all kitchen cleaning protocols were in place and followed in accordance with kitchen sanitation guidelines.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility's quality assurance (QA) program failed to implement, monitor, and revise as needed the action plan developed for the recertification survey on 8/26/21 in order to achieve and sustain compliance. This was for a recited deficiency on a recertification survey on 1/10/23. The deficiency was in the area of medication storage. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F761: Based on observations, staff interviews and record reviews, the facility failed to: 1) Discard expired medications, loose capsules from	F 867	1. Per the 2567, based on staff interview and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee ut into place following the 08/26/21 recertification survey. This was for a recited deficiency in the area of Medication Storage. This deficiency was cited again on the current recertification survey. The continued failure during two federal survey of record shows a pattern of the facility's inability to sustain an effective QAA program. This tag is cross referenced to: F761). The District Director of of Operations has provided 1:1 education with the Administrator on 12/21/22. No adverse outcomes were identified. 2. All residents receiving medications	2/10/23

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F 867	Continued From page 39 an opened stock bottle of medication and one unidentified tablet lying on the bottom of a medication (med) cart drawer; and 2) Store medications in accordance with the manufacturer's storage instructions. This was occurred for 2 of 3 medication carts observed (Station 2 A/B Med Cart and Station 1 Med Cart). During the previous recertification surveys on 8/26/21, the facility failed to date opened medications in 2 of 6 medication administration carts and failed to remove expired medications stored in 1 of 6 medication administration carts. During an interview on 12/21/22 at 3:40 PM, the Administrator indicated that all the citations would be reviewed, and a plan of correction would be put in place. The Administrator continued that the Quality Assistance and Assurance (QAA) committee met regularly, identified areas of concern, conducted the root cause analysis, created the plan of correction, and discussed the outcome. The Interdisciplinary Team will continue monitoring until the deficient area concerns will be resolved.	F 867	have the potential to be affected by the deficient practice. The District Director of Operations has provided 1:1 education with the Administrator on 12/21/22 in-service education was provided by the Director of Nursing, SDC/Infection Preventionist beginning on 2/9/23 on proper policies and procedures related to Medication Storage and Labeling. A full house audit of all medication carts was performed and was conducted by the Director of Nursing, and Infection Preventionist to ensure all Southpoint Rehabilitation and Healthcare Center staff are appropriately following Medication storage and labeling policy and procedures. 3. Mandatory all staff/agency contract staff education on policies and procedures related to Medication storage and labeling has been completed. Immediate education/intervention was provided to the Nurse #3 and Nurse #2. Full house education initiated on 12/21/22 and completed on 2/9/23. All new hires and all contracted agency staff will have this mandatory education prior to working on the unit. Daily ongoing observation and education will be provided also to maintain compliance. The District Director of Operations and/or Designee will attend the facilities QAPI monthly meetings to ensure medication storage and labeling compliance is ongoing and addressed via Ad Hoc and PIP process. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee	

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F 867	Continued From page 40	F 867	monthly times three by the Director of Nursing/Administrator/designee to ensure solutions are sustained and to address any concerns.	
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		2/10/23

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F 880	Continued From page 41 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Medical Director interviews, and record reviews, the facility staff failed to: 1) disinfect a shared blood glucose meter (glucometer) between residents in accordance with the instructions provided by the	F 880	1: No residents were harmed as a result of this deficient practice. The facility failed to disinfect a shared blood glucometer per the manufacturer guidelines in between Resident's #50 and #202. This occurred	

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F 880	Continued From page 42 manufacturer of the disinfectant wipes used for 2 of 3 residents whose blood glucose levels were checked (Residents #50 and #202). This occurred while there was a resident with a known bloodborne pathogen in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. 2) disinfect an individually assigned glucometer for a resident diagnosed with a bloodborne pathogen. This occurred for 1 of 3 residents whose blood glucose levels were observed to be checked (Resident #35). This glucometer was stored in a cloth container inside a drawer with other residents' glucometers and placed on surfaces that were not disinfected after contact. Resident glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer of the glucometer potentially exposes residents to the spread of blood borne infections. Immediate Jeopardy began on 12/19/22 when Nurse #1 was observed attempting to perform blood glucose testing for two residents on her assigned hall using a shared glucometer. Nurse #1 used an EPA-approved disinfectant wipe between the two residents but did not follow the manufacturer's instructions to allow for the wet contact time as specified for the disinfectant to be effective. Immediate Jeopardy was removed on 12/21/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential	F 880	while there was a resident with a known bloodborne pathogen in the facility. The nurse was immediately corrected on 12/19/22. Nurse #1 had a competency completed on 12/20/22 for perper disinfection of glucometers per manufacturer's guidelines technique by the DON on 12/20/22. 2. Residents that require glucometer monitoring have the potential to be affected by this deficient practice. All Licensed Nurses/Contract agency staff that care for a resident that requires a fingerstick glucometer check had a competency completed by the DON/designee to ensure they are cleaned and disinfected after each use with an approved product and procedure by 2/9/22. All residents that require a blood glucose check will have a dedicated glucometer to prevent the potential spread of bloodborne pathogens. Validated on date 1/2/23. 3. All Licensed Nurses/contract agency staff were in-serviced by the DON/designee on proper disinfection techniques for glucometer usage in between resident use. Education ensures that staff understand, even if they have an individual glucometer, they still must clean and disinfect them according to the manufacturer's recommendations. The education consist of the policy of glucometer decontamination and how glucometers are to be stored, as well as what to do if they are unable to locate additional glucometers, by 2/9/23. Nurse competencies were also completed to all Licenses Nurses/Agency contract staff	

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F 880	Continued From page 43 for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: A review of the facility's policy entitled "Glucometer Decontamination" (Revised in December 2021) read: "The center will follow manufacturer's recommendations for decontaminating glucometers used for point-of-care blood glucose monitoring to ensure a safe and effective process." The guidelines included, in part: "1. Each resident requiring blood glucose checks will have a dedicated glucometer to prevent the potential spread of bloodborne pathogens. 2. In the event that glucometers must be shared within a center, the glucometer shall be decontaminated with the center approved wipes following use on each resident. Gloves will be worn, and the manufacturer's recommendations will be followed. 3. Glucometers may be contaminated with blood and body fluids as well as other pathogens, such as would be encountered in contact precautions. The center will use a disinfectant wipe that is EPA-registered as tuberculocidal; therefore, is effective against HIV, HBV, and a broad spectrum of bacteria. Should there be an occasion that the disinfectant wipe is not available; a 1:10 bleach solution may be substituted. 4. If the disinfectant wipe is not bleach-based nor has an EPA claim as effective against C. difficile	F 880	that care for a resident requiring a blood glucose via a glucometer to ensure compliance proper disinfection techniques was used by 2/9/23. Audits of glucometer cleaning will be conducted by the DON/designee 5 times a week x 12 weeks, including all three shifts at least weekly. 4. The results of these audits/concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee monthly times three by the Director of Nursing/Administrator/designee to ensure solutions are sustained and to address any concerns.	

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spores and the glucometer has been used in a C. difficile room, a 1:10 bleach solution shall be used."

The procedure outlined the following process, in part:

"1. The nurse will obtain the glucometer along with the wipes and place the glucometer on a clean surface such as on a paper towel on the medication cart preparation area.

2. Cleaning and disinfecting the glucometer:
a. Perform hand hygiene.
b. Put on gloves.
c. Remove disinfectant wipe that is EPA-registered from container.
d, If wipe is noticeably saturated, squeeze excess liquid out over waste basket.
e. Wipe the monitor and ensure it is visibly wet.
f. Follow the wipe manufacturer's instructions for the length of time the monitor must remain wet. (May wrap glucometer with wipe in order to ensure wet for entire time instructed).
g. Allow the monitor to air dry.
h. Monitor is ready for use or placed in the appropriate clean storage location until needed.
i. Remove gloves.
j. Wash hands ..."

The manufacturer instructions for the glucometer used at the facility indicated the cleaning and disinfection procedure should be performed as recommended to minimize the risk of transmitting blood-borne pathogens. These instructions read in part, "The (Brand Name) meter should be cleaned and disinfected between each patient."

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The disinfectant wipes used at the facility for glucometer disinfection were approved for cleaning and disinfecting their (Brand Name) glucometer. The instructions on the label of the disinfectant wipes read in part: "To clean and disinfect and deodorize hard, non-porous surfaces: Wipe surface to be disinfected. Use enough wipes to treated surface to remain visibly wet to the contact time listed. Let Dry." Special instructions for cleaning and decontamination against HIV, HBV and HCV indicated, "Allow surfaces to remain wet for one minute, let air dry. For all other organisms, see directions for contact time." Mycobacterium bovis (an organism that can cause tuberculosis) was killed in 2 minutes. The instructions also indicated enough wipes should be used for the treated surface to remain visibly wet for 3 minutes to kill Clostridium difficile (C-diff) spores.

1. A medication administration observation was initiated on 12/19/22 at 4:20 PM with Nurse #1. As the medication cart was approached, a glucometer was observed to be sitting on top of the med cart. Nurse #1 was observed as she donned gloves, collected supplies (a test strip, lancet and an alcohol wipe), picked up the glucometer stored on top of the medication cart, and entered Resident #50's room to conduct a blood glucose check. The nurse exited the room. She placed the glucometer on the med cart, removed her gloves and pulled a container of disinfectant wipes out of the med cart. Nurse #1 then donned a clean pair of gloves and was observed as she wiped the glucometer with the disinfectant wipe for 3-4 seconds. After wiping, the glucometer did not appear to remain visibly wet. The nurse placed the glucometer on the top of the medication cart and discarded the

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disinfectant wipe. She then removed her gloves, performed hand hygiene with a hand sanitizer, and proceeded to prepare one oral medication for administration to Resident #50. A continuous observation was conducted as Nurse #1 administered the medication to Resident #50.

On 12/19/22 at 4:30 PM, Nurse #1 reported she needed to conduct one more blood glucose check for Resident #202 on her hall. At that time, the nurse performed hand hygiene with a hand sanitizer and collected a test strip, alcohol wipe, and lancet from the cart. She then donned gloves and inserted the blood glucose test strip into the glucometer. After she gathered up the glucometer and supplies to take into Resident #202's room, the nurse was asked to stop. At that time, Nurse #1 was asked to pull the container of disinfectant wipes from the medication cart and review the disinfection instructions to see what the manufacturer recommendations were for "wet contact time." Upon review, Nurse #1 reported the recommended wet contact time was 3 minutes. The nurse explained she had wiped the glucometer with a disinfectant wipe after using it for Resident #50 and had let it dry for 3 minutes. It was recommended the nurse consult with the facility's Director of Nursing (DON) prior to proceeding on with the next blood glucose check. The nurse was observed as she returned to the med cart carrying a second glucometer. Nurse #1 reported this second glucometer was new and she was instructed to use it for Resident #202. The nurse reported she was also instructed to label the used glucometer for Resident #50 after she disinfected it. Nurse #1 was then observed as she disinfected the used glucometer by wiping it again with a disinfectant wipe, discarding that

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wipe, and wrapping a second wipe around the glucometer to extend the wet contact time. When she did so, the nurse commented, "I hope the meter will still work." At that time, the nurse was asked if the glucometer used for Resident #50 had also been used for another resident prior to the observations made. She reported she had used the same glucometer to check Resident #91's blood glucose prior to using it for Resident #50. Documentation on Resident #91's Medication Administration Record confirmed this resident's blood glucose was also checked by Nurse #1 as scheduled on 12/19/22 at 4:30 PM.

An interview was conducted on 12/19/22 at 4:45 PM with the facility's DON immediately after the blood glucose checks were observed. During the interview, the concern identified with failure to disinfect a shared glucometer in accordance with the disinfectant wipe's instructions was discussed. The DON reported all residents requiring blood glucose checks should have had an individual, dedicated glucometer stored on the med cart. She stated a shared glucometer should not have been used but if it was, it should have been disinfected with the disinfectant wipe providing 3 minutes of wet contact time. The DON reported Nurse #1 was a long-time employee of the facility and she did not understand why a shared glucometer had been used for the blood glucose checks.

An interview was conducted with the facility's Administrator and DON on 12/20/22 at 10:20 AM. During the meeting, the DON confirmed there was only one working glucometer on the medication cart used by Nurse #1 the afternoon of 12/19/22. When the Administrator asked the DON why individual glucometers were not on the

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med cart or why the nurse did not go to retrieve more meters, she stated she did not know. The DON reported each resident should have had his own dedicated glucometer on the medication cart. When the topic of glucometer disinfection was discussed, the DON reported once a glucometer was only wiped with a disinfection wipe, the solution would dry on the glucometer "within seconds."

A telephone interview was conducted with the facility's Medical Director on 12/21/22 at 1:45 PM. During the interview, the Medical Director reported he had been informed of the concern regarding failure to disinfect a shared glucometer between residents. He stated it was his understanding the facility was working on the re-education of staff and implementing measures to ensure compliance with the disinfection of glucometers. When asked, the Medical Director stated he had no questions at the time of the interview.

2. Resident #35 had the diagnosis of chronic hepatitis C (viral infection of the blood dormant stage) and diabetes according to the admission diagnoses list.

Resident #35's quarterly Minimum Data Set dated 11/14/22 documented the resident was oriented and had the diagnoses of viral hepatitis and diabetes.

On 12/20/22 at 11:55 am Nurse #7 was observed checking Resident #35's blood sugar with a glucometer. Nurse #7 disinfected the center surface of the medication cart top with an EPA-approved disinfectant wipe. There was a towel and other objects on top of the cart top. She used hand sanitizer and retrieved Resident

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#35's individual blood glucometer from inside a fabric storage container. The fabric storage container was stored in a drawer with other residents' glucometers in their fabric storage containers. Nurse #7 laid the glucometer case on top of the medication cart in the disinfected area, opened the case, and checked its contents. Nurse #7 took the open case with glucometer, test strip, and alcohol pad and entered Resident #35's room, placed paper towels on the bedside table and then placed the open fabric storage container on the paper towels. Nurse #7 put on gloves and retrieved a sample of blood for the glucometer reading. Nurse #7 removed her gloves, washed her hands with soap and water, put on another pair of gloves, picked up the glucometer case and glucometer with used test strip in place, and walked back to the medication cart. Nurse #7 discarded the used test strip and sharps by gloved hand into a sharps container. Nurse #7 placed the glucometer and case on top of the towel and items on the cart, not the disinfected area. Nurse #7 wiped the glucometer with an alcohol pad for less than one minute and placed the glucometer back into the container and zipped it closed. Nurse #7 removed her gloves, used hand sanitizer, and placed Resident #35's glucometer container back in the drawer together with the other residents' glucometer containers (four containers).

An interview was conducted at 12:05 pm with Nurse #7. Nurse #7 stated that she cleaned the individual resident's glucometers with alcohol and was not aware that the glucometer was required to be cleaned with an EPA-approved disinfectant wipe. She was asked to pull the container of disinfectant wipes from the medication cart and to review the disinfection instructions to see what

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the manufacturer recommended for "wet contact time." The nurse reported it was 3 minutes. The instructions on the label of the disinfectant wipes read in part: "To clean, disinfect and deodorize hard, non-porous surfaces: Wipe the surface to be disinfected. Use enough wipes to treat surface to remain visibly wet to the contact time listed. Let Dry." Special instructions for cleaning and decontamination against Hepatitis indicated, "Allow surfaces to remain wet for one minute, let air dry."

On 12/20/22 at 12:15 pm an interview was conducted with the Director of Nursing (DON). The DON stated she was not aware that an individual resident's blood glucometer that was stored together in the medication cart required more than an alcohol wipe for disinfection if not shared with other residents. The DON stated she would address the infection control/ disinfection for the residents' blood glucometers.

A telephone interview was conducted with the facility's Medical Director on 12/21/22 at 1:55 PM. During the interview, the Medical Director reported he had been informed of the concern regarding failure to disinfect a shared glucometer between residents. He stated it was his understanding the facility was working on the re-education of staff and implementing measures to ensure compliance with the disinfection of glucometers. The Medical Director stated that he was aware Resident #35 had chronic Hepatitis C. The resident was treated before admission to the facility. The Medical Director stated testing of the other 3 residents with glucometers on the same medication cart would not be necessary.

The facility's Administrator and DON were

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informed of the immediate jeopardy on 12/20/22 at 10:20 AM.

The facility provided the following credible allegation of immediate jeopardy removal.

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

According to the surveyor, the facility did not allow for the required dwell time for the disinfectant wife to be effective after use of the glucometer on Resident #50 and before the nurse was going to use the same glucometer and test blood sugar for Resident #202. The facility also failed to use the appropriate disinfectant wipe to decontaminate the glucometer for Resident #35. In addition, glucometers are now to be stored in a plastic case in the resident's bedside nightstand. Therefore, the fabric storage containers have been discarded.

The Director of Nursing has completed an audit of all current residents to identify those with physician orders for fingerstick blood glucose monitoring. Each resident that has an order for blood glucose monitoring has been given a new individually assigned glucometer that has been placed in their bedside nightstand as of 12/20/22.

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

Individually assigned glucometers that are placed in the residents' bedside nightstand will be cleaned according to the manufacturer's

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recommendations. Extra glucometers are available for licensed nursing staff who do the fingerstick blood sugar (FSBS) to ensure new admissions or residents with new orders for FSBS's have their own glucometer. Licensed nurses will be educated by the Director of Nursing or Assistant Director of Nursing regarding where extra glucometers are stored.

Current licensed nurses, including agency and PRN nurses, will receive training on the importance of cleaning and disinfecting the glucometer per manufacturer' s recommendations as needed. Education ensures that staff understand, even though the residents have their own glucometers, they still have to clean and disinfect them according to the manufacturer's recommendations. Education was initiated on 12/20/22 by the Assistant Director of Nursing/Director of Nursing on each shift until all licensed nursing staff have completed the training. Licensed nursing staff will not be permitted to provide direct care until such education is completed. The education consists of a review of the center's policy on Glucometer Decontamination. Nurses are also educated on how glucometers are to be stored in resident rooms as well as where to find additional glucometers if needed. Nurses are also educated on what to do if they are unable to locate additional glucometers. This education will be completed verbally as well as providing written materials.

On 12/20/22, the Director of Nursing communicated with the local public health authority to alert them of the alleged deficient practice and obtain guidance on how to assess and test residents for possible exposure to

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bloodborne pathogens. Assessment and testing of Resident #35, Resident #50 and Resident #202 will be conducted based on the public health authority's instruction.

Observations of glucometer cleaning will be conducted by the Director of Nursing, Assistant Director of Nursing or licensed nurse designee at least once per day for 30 days, including all three shifts at least weekly. After 30 days, the Director of Nursing, the Assistant Director of Nursing or a licensed nurse designee will conduct observations at least once weekly for 30 days. Findings of these observations will be discussed monthly at the center's Quality Assurance Performance Improvement Committee meeting. The observations began 12/20/22.

Date of Removal: 12/21/22

The facility's credible allegation of immediate jeopardy removal was validated on 12/21/22. The validation was evidenced by nurse observations and interviews conducted with regards to the required infection control practices for the use of glucometers. All nurses who were interviewed reported they had received the required in-service training and were made aware of the facility's policy to use individually assigned glucometers for each resident requiring blood glucose monitoring. The education included review of the facility's infection control policy, manufacturer instructions related to glucometer disinfection, and a return demonstration. The nurses reported they were informed each resident's individual glucometer was now stored in his or her room. Multiple observations also confirmed the glucometers were stored inside a non-porous container kept in the residents' rooms. The

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F 880	Continued From page 54 credible allegation was validated, and the immediate jeopardy was removed on 12/21/22.	F 880		