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	345434	A. BUILDING ______ B. WING ______	C 03/02/2023

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 2/28/23 through 3/2/23. Event ID# 6UU111. The following intakes were investigated : NC00197009, NC00197407, NC00197470, NC00198018, NC00198435, NC00198440, NC00198451, NC00198469, NC00199046 Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (G) CFR 483.12 at tag F610 at a scope and severity (G) 4 of the 25 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews	F 600	Past noncompliance: no plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/20/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 with residents and staff, the facility failed to protect a resident's right to be free from mistreatment for 2 of 4 residents investigated for staff to resident abuse (Resident #3 and Resident #5). Resident #5 felt angry when an employee made a threatening gesture and treated her roughly during incontinence care, failing to stop pulling on her when resident requested. Resident #3 experienced pain and anxiety when an employee handled her roughly during incontinence care and failed to stop providing care when she requested. The findings included: 1. Resident #5 was admitted to the facility on 1/13/2023 with diagnoses that included chronic kidney disease, diabetes, and hypoventilation syndrome (neurological disorder characterized by inadequate breathing). Resident #5's annual Minimum Data Set (MDS) dated 1/30/2023 indicated the resident was cognitively intact, had adequate hearing and vision, required extensive assistance with activities of daily living. She required extensive assistance with bed mobility and toileting. The resident was coded as occasional incontinent of urine and frequently incontinent of bowel. Resident #5 received a diuretic 7 out of 7 days during the assessment period. Resident #5's comprehensive care plan was last updated 2/10/2023. The resident had a focus for self-care deficit related to diagnoses. Interventions included extensive assistance by two staff members for toileting and personal hygiene.	F 600	correction required.	

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Continued From page 2

An interview was conducted with Resident #5 on 2/28/2023 at 1:30PM. She stated Nurse Assistant (NA) #1 was working the hall Friday night shift on 2/10/2023. Resident #5 stated around 4:00 AM on 2/11/2023 she called out for incontinence care. She stated NA #1 entered her room and asked, "what do you want?". The resident informed the NA she needed to be cleaned. NA#1 stated she would have to wait until she could find another NA to assist. Resident #5 stated NA #1 entered her room along with NA#2. During incontinence care, NA #1 pulled roughly on the resident's left leg. When Resident #5 yelled out in pain and asked the NA to stop pulling on her left leg, the NA ignored her and did not stop. Resident #5 stated after the two NAs completed incontinence care, as NA#2 had her back turned exiting the room, she requested to be repositioned. NA #1 made a threatening gesture by taking her finger and running it horizontally across the base of her own throat. Resident #5 stated the gesture and the rough treatment made her angry and anxious. She called out for her nurse, Nurse #1, and reported it immediately to the nurse.

On 2/28/2023 at 2:32PM a phone interview was conducted with NA#2. She stated she was in the room with NA #1 when she performed care for Resident #5 on the early morning hours of 2/11/2023. She stated she was not assigned to the hall but NA#1 told her Resident #5 required two persons to turn, so she agreed to help NA #1. She stated she felt NA #1 was verbally rude to Resident #5 and she did observe NA #1 pull on the resident's leg causing her to yell out in pain. She stated NA#1 did not release the resident's leg but continued to provide care, ignoring the resident's request to stop. NA#2 stated NA#1

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handled Resident #5 rougher than she handles residents.

A phone interview was conducted with NA#1 on 2/28/2023 at 2:35PM. She stated she was contracted through a nursing agency and had never worked a night shift at the facility. She was not familiar with any of the residents. She did not know why any of the residents would have reported she was rough with them. She stated there was one resident who was bariatric and required a lot of effort to turn. She had asked another NA to assist her with that resident. She did not recall making any of the residents angry and denied making any gestures to any residents.

On 3/1/2023 at 10:00 AM a phone interview was conducted with Nurse #1. She stated Resident #5 reported NA#1 was rude, treated her roughly, and made a threatening gesture by taking her finger and running horizontally across the base of her own throat around 4:00 AM on 2/11/2023. Nurse #1 stated she assured the resident that she was safe and no one was going to hurt her.

2.Resdient #3 was admitted to the facility on 1/14/2022 with diagnoses that included chronic renal disease, and bilateral lower leg venous hypertension with stasis ulcers.

The resident's annual Minimum Data Set (MDS) dated 12/15/2022 indicated the resident was mildly cognitively impaired, required extensive assistance with activities of daily living, and was dependent upon staff for assistance with toileting and personal hygiene. The resident was coded as always incontinent of urine and frequently incontinent of bowel.

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F 600	Continued From page 4 An interview was conducted with Resident #3 on 2/28/2023 at 10:30AM. She stated she did not recall the date or time of the incident or the name of the Nurse Assistant (NA) who handled her roughly. She reported she pressed her call bell and the NA came into her room, snatched the curtain back and asked, "what do you want?" Resident #3 stated she was wet and needed to be cleaned. She stated the NA snapped the curtain back and stated, "you will have to wait". Resident #3 stated when the NA returned, she was rough with her and grabbed her leg to turn her. She told the NA she was hurting her and the NA ignored her. Resident #3 stated she told the NA to stop or she was going to call 911 and the NA told her, "go ahead, I don't care". Resident #3 stated she did not report the incident to anyone until her daughter visited. She did not recall the date or time she told her daughter. Resident #3 stated the NA did not return to her room that night and she had not seen the NA since that incident. Resident #3 stated the incident made her feel anxious. When asked why she did not report the incident to staff, she stated she was scared she might anger the NA who hurt her. The staffing assignment sheet for 2/10/2023 indicated NA #1 was assigned to Resident #3 on 2/10/2023 from 7:00PM until 7:00AM on 2/11/2023. On 2/28/2023 at 1:16PM a phone interview was conducted with Resident #3's Responsible Party (RP). She stated she visited Resident #3 on 2/11/2023 around 5:30PM and it was during that visit Resident #3 made her aware a staff member had treated her roughly and been rude to her around 9:00PM the night before. The RP stated she went to the nurse station and requested the	F 600		

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name of the NA assigned to Resident #3 the night before. She was told NA #1 was assigned to Resident #3. The RP stated she went back and asked her mother what the NA looked like. Resident #3 was able to describe the color of her clothing and the fact she had long false eyelashes. The staff confirmed NA #1 fit the description and that she was a agency nurse. The RP stated she then called the nursing agency and spoke with an individual regarding the behavior of their NA. She stated she did not report the incident to the facility Administrator.

During an interview with the Administrator on 3/1/2023 at 9:40AM, she stated she was not made aware of the incident until 2/12/2023. She stated she received a call from the Director of the staffing agency who employed NA#1 and NA#2. The Director informed her a family member of Resident #3 called her an alleged mistreatment by NA#1.

The facility provided the following corrective action plan with a completion date of 2/13/2023

Problem identified: Resident # 5 alleged Nursing Assistant (NA)#1 made a threatening gesture toward her and handled her roughly during incontinent care.

Immediate Action:
The Administrator completed education on 2/12/2023, for the unit managers, wound nurse, and supervisors regarding the Abuse Policy and Procedure, definitions of abuse, and residents' rights to be free from mistreatment. The Assistant Director of Nursing (ADON) and unit managers provided education to the facility staff on 2/12/2023, regarding the Abuse Policy and

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F 600	Continued From page 6 Procedure to include the definition of abuse and implementing an intervention to keep resident safe. Education included staff will stop providing care at resident's request. Staff not present for the education, will be educated prior to return to work. Newly hired staff and agency staff will be educated during new hire orientation. Identification of other Residents: The ADON and the Administrator reviewed incident reports and grievance reports for the last 30 days to identify concerns of abuse or mistreatment. There were no other allegations identified. The licensed nurses completed interviews 2/12/2023 for residents with BIMS score of 10 or higher, asking if they felt safe in the facility and were there any concerns of abuse. There were not concerns identified. The license nurses completed skin assessments on 2/12/2023 for residents with BIMS score of less than 10 to identify bruises/injuries that had not been reported and/or treated. There were no concerns identified. Systemic Changes: The ADON and unit managers provided education to the facility staff on 2/12/2023 regarding the abuse policy and procedure to include definition of abuse, residents' rights to be free of mistreatment, and implementing an intervention immediately to keep resident(s) safe. Education included staff will stop providing care at resident's request. Staff not present will be educated prior to return to work. Newly hired staff will be educated during new hire orientation. Quality Assurance:	F 600		

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The Administrator and/or Social Worker (SW) will interview 10 alert and oriented residents weekly for 4 weeks then 20 per month for 2 months to identify any concerns of abuse.
The DON and/or the ADON will review incident reports and grievance reports 5x week for 4 weeks then 3x week for 2 months to identify concerns of abuse.
The Administrator and/or the DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.
The Administrator and/or the DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.

Completion dated 2/13/2023

The past noncompliance was validated on 3/1/2023 when staff interviews and interviews with agency staff, revealed that they had received recent education on the Abuse policy and procedures and resident rights to be free from mistreatment. The education included the staff need to stop providing care if a resident request they stop.

Facility documentation revealed staff were trained on the following topics: Abuse policy and procedures, resident's rights education, and interviewing for abuse or mistreatment. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Newly hired staff and agency staff received an in-service packet prior to working and this was verified by the facility trainers and added to the orientation checklist.

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F 600	Continued From page 8 The facility deficiency was corrected on 2/13/2023.	F 600		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, and the Administrator, the facility failed to report an allegation of abuse to the administrator immediately per facility's policy and protocol and failed to immediately assess other residents who were under the care of Nurse assistant (NA) #1, and protect all residents from verbal abuse and mistreatment by allowing NA #1 to continue working after an allegation of abuse was reported to facility staff. The deficient practice occurred for 1 of 3 residents (Resident #5) sampled for abuse, however the deficient	F 610	Past noncompliance: no plan of correction required.	

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practice had the potential to impact other residents.

The findings included:

The facility provided a paper form titled, " Abuse and Neglect Protocol". The policy was dated 6/13/2021. The policy read in part, "employees, facility consultants and /or attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services (DON). In the absence of the DON, such reports may be made to the Nurse Supervisor on duty". The policy also included the following, "If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident."..” Employees of the facility who have been accused of resident abuse shall be suspended from duty until the results of the investigation has been reviewed by the Director of Nursing/Designee or Administrator."

Resident #5 was admitted to the facility on 1/13/2023.

Resident #5's annual Minimum Data Set (MDS) dated 1/30/2023. indicated the resident was cognitively intact, had adequate hearing and vision, required extensive assistance with activities of daily living. She required extensive assistance with bed mobility and toileting. Resident #5 received a diuretic (causes increased urine output) 7 out of 7 days during the assessment period.

An interview was conducted with Resident #5 on 2/28/2023 at 1:30PM. She stated NA #1 was

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assigned to her hall Friday, night shift, on 2/10/2023. Resident #5 stated around 4:00 AM on 2/11/2023 she called out for incontinence care. She stated NA #1 entered her room and asked, "what do you want?". The resident informed the NA she needed to be cleaned. NA#1 stated she would have to wait until she could find another NA to assist. Resident #5 stated NA #1 entered her room along with NA#2. During incontinence care, NA #1 pulled roughly on the resident's left leg. When Resident #5 yelled out in pain and asked the NA to stop pulling on her left leg, the NA ignored her and did not stop. Resident #5 stated after the two NAs completed incontinence care, as NA#2 had her back turned exiting the room, she requested to be repositioned. NA #1 made a threatening gesture by taking her finger and running it horizontally across the base of her own throat. The NA then exited the room without repositioning her as she had requested. Resident #5 stated the gesture and the rough treatment made her angry and anxious. She called out for her nurse, Nurse #1, and reported it immediately to the nurse.

On 2/28/2023 at 2:32PM a phone interview was conducted with NA#2. She stated she was in the room with NA #1 when she performed care for Resident #5 on the early morning hours of 2/11/2023. She stated she felt NA #1 was verbally rude to Resident #5 and she did observed NA #1 pull on the resident's leg causing her to yell out in pain. She stated NA#1 did not release the resident's leg but continued to provide care, ignoring the resident's request to stop. NA#2 stated NA#1 handled Resident #5 rougher than she handles residents. NA #2 stated she did not witness NA #1 make any gestures toward Resident #5. NA#2 stated she did not report the

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incident to the nurse or the nurse supervisor.

On 3/1/2023 at 10:00 AM a phone interview was conducted with Nurse #1. She stated Resident #5 reported NA#1 was rude, treated her roughly, and made a threatening gesture by taking her finger and running horizontally across the base of her own throat around 4:00 AM on 2/11/2023. Nurse #1 stated she assured the resident that she was safe, and no one was going to hurt her. Nurse #1 stated she did not recall there being a nursing supervisor in the facility that night, so she reported the incident to the weekend supervisor when she arrived at the facility for here regularly scheduled shift around 8:00 AM. She further stated she was not aware the incident should have been reported immediately.

A phone interview was conducted with the weekend nurse supervisor, Nurse #2, on 3/1/2023 at 10:15 AM. She stated Nurse #1 made her aware of the incident between Resident #5 and NA#1 around 8:00AM on 3/1/2023. She was not in the facility when the incident occurred at 4:00AM. Nurse #2 stated she followed the facility's policy and reported the incident to the Nurse on call. She stated the nurse on call, Nurse #3, was in the facility when she reported to her what had occurred. They had a brief conversation about the incident, decided it was not abuse. She stated she did not make the Administrator aware of the incident.

On 3/1/2023 at 10:30AM an interview was conducted with Nurse #3, the on-call nurse. She recalled Nurse #2 informed her of an incident that occurred on the morning of 2/11/2023 between Resident #5 and NA #1 around 8:30AM, shortly after she arrived at the facility. She was

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told Resident #5 alleged NA #1 took her finger and ran it horizontally across the base of her throat as a gesture. She did not recall being told about the NA being rough. Nurse #3 stated she and Nurse #2 talked about the incident and determined it was not abuse. She did not inform the Administrator about the incident.

An interview was conducted with the Administrator on 3/1/2023 at 9:40AM, she stated she was not made aware of the incident until 2/12/2023. She did not recall what time of day she was made aware. She stated she received a call from the Director of the staffing agency who employed NA#1 and NA#2. The Director informed her a family member of another resident (Resident #3) called her an alleged mistreatment by NA#1. The Administrator stated she immediately went to the facility and began an investigation. Both NA#1 and NA#2 were terminated. After resident interviews and assessments of affected residents, the facility substantiated the allegations, and all employees were educated on what constitutes abuse, timely reporting of allegations, and to stop providing care when a resident requests to stop.

The facility provided the following corrective action plan with a completion date of 2/13/2023

Problem identified: Resident # 5 alleged Nursing Assistant (NA)#1 made a threatening gesture toward her and handled her roughly during incontinent care. Resident #5 reported the mistreatment to Nurse #1 at 4:00AM on 2/11/2023. Nurse #1 reported the incident to the weekend Nursing Supervisor on 2/11/2023 at 8:00AM. The incident was reported to the Administrator on 2/12/2023, late afternoon.

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	345434	A. BUILDING ______ B. WING ______	C 03/02/2023

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Immediate Action:
The Administrator completed the Facility Reported Incident (24 hr report) on 2/12/2023 when the facility was made aware of an allegation of abuse regarding Resident #5 and Resident #3. The Administrator completed education on 2/12/2023 , for the unit managers, wound nurse, and supervisors regarding the Abuse Policy and Procedure and reporting of the allegation of abuse to the Director of Nursing, Administrator, and State Agency. The Assistant Director of Nursing (ADON) and unit managers provided education to the facility staff on 2/12/2023, regarding the Abuse Policy and Procedure to include reporting all allegations of abuse promptly to the Director of Nursing and/or Administrator and implement and intervention immediately to keep resident(s) safe. Staff not present for the education will be educated prior to return to work. Newly hired staff and agency staff will be educated during new hire orientation.

Identification of other Residents:
The ADON and the Administrator reviewed incident reports and grievance reports for the last 30 days to identify concerns of abuse and validate the allegation was reported as required. There were no other allegations identified.
The licensed nurses completed interviews 2/12/2023 for residents with BIMS score of 10 or higher, asking if they felt safe in the facility and were there any concerns of abuse that had not been reported. There were not concerns identified.
The license nurses completed skin assessments on 2/12/2023 for residents with BIMS score of less than 10 to identify bruises/injuries that had not been reported. There were no concerns

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identified.

Systemic Changes:
The ADON and unit managers provided education to the facility staff on 2/12/2023 regarding the abuse policy and procedure to include reporting all allegations of abuse promptly and the need to implement an intervention immediately to keep residents safe. Staff not present will be educated prior to return to work. Newly hired staff will be educated during new hire orientation.

Quality Assurance:
The Administrator and/or Social Worker (SW) will interview 10 alert and oriented residents weekly for 4 weeks then 20 per month for 2 months to identify concerns of abuse and will validate that the allegation was investigated and reported to the DON/Administrator and State Agency.
The DON and/or the ADON will review incident reports and grievance reports 5x week for 4 weeks then 3x week for 2 months to identify concerns of abuse and will validate that the incident or concern was investigated and reported to the DON/Administrator and State agency.
The Administrator and/or the DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.
The Administrator and/or the DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.

Completion dated 2/13/2023.

The past noncompliance was validated on

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F 610	Continued From page 15 3/1/2023 when staff interviews and interviews with agency staff, revealed that they had received recent education on the Abuse policy and procedures and immediately reporting any allegations of abuse. The education included documentation and reporting to the DON or Administrator immediately when they become aware of reported abuse, suspected abuse, and/or injury and take immediate action to ensure the safety of resident(s). Facility documentation revealed staff were trained on the following topics: Abuse policy and procedures, definition of abuse, and nurse notification to management. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Newly hired staff and agency staff received an in-service packet prior to working and this was verified by the facility trainers and added to the orientation checklist. The facility deficiency was corrected on 2/13/2023.	F 610		
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	F 761		3/7/23

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F 761	Continued From page 16 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident and Medication Aide, the facility failed to secure two topical medications for 1 of 2 residents (Resident #3) reviewed for wound care. The findings included: Resident #3 was admitted to the facility on 1/14/2022 with diagnoses that included chronic renal disease, and bilateral lower leg venous hypertension with stasis ulcers. The resident's annual Minimum Data Set (MDS) dated 12/15/2022 indicated the resident was mildly cognitively impaired, required extensive assistance with activities of daily living, and was dependent upon staff for assistance with toileting and personal hygiene. The MDS also indicated Resident #3 had 2 venous/arterial ulcers present at the time of the assessment and received non-surgical dressings and application of	F 761	F 761 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 02/28/23,The licensed nurse removed the bottle of zinc and bottle of 2% ketoconazole shampoo from Resident # 3 bedside table. On 02/28/23, The Director of Nursing educated the family member of Resident #_3___, regarding medications at bedside. On 02/28/23, the licensed nurse notified the physician regarding the bottle of zinc and shampoo on Resident #3 bedside	

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F 761

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ointments or medications.

Resident #3's medical record review revealed a physician's order dated 3/11/2022 that read;
2% Ketoconazole shampoo. Apply to body topically every day shift on Monday, Wednesday, and Friday for skin integrity. Add to bath water, leave on skin for 5 minutes and rinse.

The resident's medical record also revealed a physician's order dated 9/6/2022 that read;
Zinc oxide, apply to low back every day shift for protection.

On 2/28/2023 at 10:30 AM during an interview a bottle of 2% Ketoconazole and a tube of Zinc oxide were observed to be sitting on the patient's bedside table. The resident stated the medications were for her skin and she keeps the medications bedside.
An interview was conducted with the Medication Aide (MA) on 2/28/2023 at 12:05PM. She stated she noticed the medications at the bedside when she administered the resident's morning medications. She did not really think about it at the time. She further stated the medications should be secured and the resident did not have an order to self-administer the medications. The MA further stated the Ketoconazole is added to the Resident's bath water when she gets a bed bath, so it is kept bedside.

A interview was conducted with the Director of Nursing on 3/1/2023. She stated medications should be secured on the medication cart if the resident did not have an order to self-administer.

F 761

table. No new orders were given.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 03/07/23, the nursing staff completed an audit of current resident rooms to validate those medications, to include over the counter or prescription, were not left at bedside. There were 8 other residents with over the counter medications found at bedside, and the medications were removed. The Medical Director was notified of the medications found at bedside. There was no negative outcome of medication at bedside and no new orders indicated.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 03/07/23, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit managers (UM) and nursing supervisors completed education for facility staff regarding medications at bedside. They were educated that medications were not to be left at bedside and if a medication was found at bedside, it should be removed and given to the licensed nurse. The licensed nurse will notify the physician for orders is

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F 761	Continued From page 18	F 761	warranted. If a resident requests for medication to be left in room, the nurse will assess the resident using the “Self-Medication Administration assessment”, to determine if the resident is able to self-administer the medication. If medication is left in room, it must be kept in a locking drawer or box. Facility does not have any residents that self-medicate at this time. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON, UM and or nursing supervisors will complete an audit of 20 resident rooms weekly x 4 weeks then 40 resident rooms monthly x 2 months, to validate there are no medications left at bedside. The DON will review the audits monthly and adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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F 761	Continued From page 19	F 761	Indicate dates when corrective action will be completed;	