STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

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E 000	Initial Comments An unannounced Recertification survey was conducted on 02/19/23 through 03/03/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 3PJZ11.	E 000		
F 000	INITIAL COMMENTS A Recertification survey was conducted from 02/19/23 through 03/03/23. Event ID# 3PJZ11. Substandard Quality of Care was identified at: CFR 483.25 at tag F687 at a scope and severity of (H). An extended survey was conducted. The 2567 was amended to reflect changes as result of IDR conducted on 4/17/23.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		4/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2023

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F 583	Continued From page 1 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide a resident with privacy when Resident #29 was observed lying in bed with his naked body exposed when door to the hallway was opened and the privacy curtain not pulled around the bed in a semi-private room. The deficient practice affected 1 of 1 resident reviewed for privacy. The reasonable person concept was applied to Resident #29 as residents have an expectation of privacy in their home environment. Findings included: Resident #29 was admitted to the facility on 07/28/22 with medical diagnoses which included in part intracerebral hemorrhage with and hemiparesis. Resident's 01/27/23 annual Minimum Data Set	F 583	Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	

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F 583	Continued From page 2 (MDS) assessment revealed that resident had severe cognitive impairments and needed extensive assistance with bed mobility, transfers, bathing, and toileting. Observation on 02/21/23 at 10:55 AM revealed upon knocking and entering Resident #29's room, resident was lying in bed naked with full frontal exposure. The privacy curtain was not pulled around the resident's bed. Resident #29 was in a semi-private room and his roommate was present. Interview on 02/21/23 at 11:05 AM with Nursing Aide (NA) #1 revealed she was a new NA and forgot to pull the privacy curtain around Resident #29 when she gave him a bed bath. Interview on 02/21/23 at 8:25 AM with the Administrator revealed that she expected that residents would not be exposed and their privacy would be maintained. The Administrator further stated that privacy curtains were to be utilized to prevent residents being exposed to other residents, staff, or visitors. Interview on 02/23/23 at 1:30 PM with the Director of Nursing (DON) revealed residents should not be exposed. The DON stated nursing staff should pull the privacy curtain around the resident whenever Activities for Daily Living (ADL) care, baths, wound care, or showers were given, which had the potential to expose the resident.	F 583	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F583 Personal Privacy/Confidentiality of Records On 2/21/23, the nursing assistant immediately pulled privacy curtain and continued care for resident # 29. On 2/21/23, the Staff Development Coordinator (SDC) verbally educated nursing assistant #1 (NA) regarding Resident Rights with emphasis on pulling privacy curtain, closing blinds and doors when providing care to a resident to ensure resident right to privacy and dignity. On 3/16/23, the Social Worker initiated questionnaires with all alert and oriented residents regarding privacy. This audit is to identify any concerns related to staff providing resident privacy during personal care to include pulling privacy curtain when indicated, medical treatment, telephone communications, and/or during family meetings or visits to the facility. The Social Worker will address all concerns identified during the audit to include but not limited to education of staff. Questionnaires will be completed by 4/3/23. On 3/16/23, the Unit Facilitator and Quality Assurance nurse (QA) initiated resident care audits with all nurses,	

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F 583	Continued From page 3	F 583	nursing assistants to include NA #1. This audit is to ensure staff maintained resident personal privacy during medical treatment and personal care by pulling privacy curtain and/or closing blinds/doors when indicated. The Unit Facilitator and/or QA nurse will address all concerns identified during the audit to include but not limited to providing resident privacy when indicated and/or education of staff. Audit will be completed by 4/3/23. After 4/3/23, any nurse, nursing assistant and/or therapy staff who have not worked or completed the audit will completed upon next scheduled work shift. On 3/16/23, the SDC initiated in-services with all nurses, nursing assistants and therapy staff regarding Resident Rights with emphasis on resident right to personal privacy during medical treatment and personal care to include pulling privacy curtain/closing blinds and doors when indicated. In-service will be completed by 4/3/23. After 4/3/23, any nurse, nursing assistant and/or therapy staff who have not worked or received the in-service will completed upon next scheduled work shift. All newly hired nurses, nursing assistants or therapy staff will be in-serviced during orientation regarding Resident Rights. The Unit Facilitator and QA nurse will complete 10 resident care audits with all nurses, nursing assistants to include NA #1 and therapy staff weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff maintained resident personal	

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F 583	Continued From page 4	F 583	privacy during medical treatment and personal care by pulling privacy curtain and/or closing blinds/doors when indicated. The Unit Facilitator and QA nurse will address all concerns identified during the audit to include but not limited to providing resident privacy when indicated and/or re-training of staff. The Director of Nursing (DON) will review the resident care audits weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of Resident Care Audits to the Quality Assurance (QA) Committee monthly x 2 months. The QA Committee will meet monthly x 2 months and review the Resident Care Audits to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		4/3/23

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F 584	Continued From page 5 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: 1a) ensure the residents rooms were free from damaged drywall in 10 of 10 resident rooms noted to have drywall wall damage (101, 104, 114, 116, 203, 214, 217,303, 815, and 817), 1b) replace 1 of 1 missing privacy curtains in 1 of 4 shower rooms (300-Hall), and 1c) failed to replace broken or missing floor tiles next to shower drain in 1 of 4 shower rooms (100-Hall); 2a) clean and disinfect dried feces off	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment On 2/21/23, the Maintenance Director initiated the repair of damaged drywall to rooms 101, 104, 114, 114, 116, 203, 214, 217, 303, 815 and 817. Repairs will be completed by 4/3/23. On 2/26/23, the housekeeping staff	

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F 584	Continued From page 6 a resident's room floor, and 2b) tell housekeeping staff to clean and disinfect the hallway area where Nursing Aide (NA) dropped soiled linen, for 2 of 2 resident rooms (Room 106 and Room 201) that were observed for environment. Findings included: An initial tour of the facility was conducted on 02/20/23 at 10:30 AM., revealed damaged drywall in 10 of 10 resident rooms observed to have drywall wall damage (101, 104, 114, 116, 203, 214, 217,303, 815, and 817). 1a. An observation on 02/21/23 at 10:35 AM revealed 10 of 10 resident rooms were noted to have drywall wall damage next to resident beds (101, 104, 114, 116, 203, 214, 217,303, 815, and 817). An interview and facility tour of the facility was conducted with the Maintenance Director (MD) on 02/21/23 at 10:45 AM. The MD stated there were multiple areas on the 100, 200, and 800 halls that needed to be addressed, repaired, or replaced. He said he often work on the 100,200, and 800 hall repairs after his shift and on weekends, when he had the time. He stated he had one assistant but was still able to keep up with facility repairs. He said maintenance was responsible for repairing or replacing items in the facility. An interview was conducted with the Director or Nursing (DON) on 02/21/23 at 11:45 AM. The DON stated it was her expectation for all the residents to have a safe and homelike environment that was in good repair, and that she was aware of the dry wall dammage in a mumber of residents rooms that needed to be repaired.	F 584	replaced the privacy curtain on the 300-hall shower room. On 3/16/23, the Maintenance Director initiated repair of the broken/missing floor tiles next to the shower drain on the 100-hall. Repair will be completed by 4/3/23. On 2/19/23, Nurse #1 cleaned the brown/black substance off the floor of room #106. The housekeeper then cleaned and disinfected brown/black substance on the floor in room #106. On 2/21/23, Housekeeping staff cleaned and disinfected hallway area of the 100-hall following nursing assistant dropping soiled linen on the floor. On 2/21/23, the Staff Development Coordinator verbally educated nursing assistant #3 (NA) regarding infection control with emphasis on bagging all trash and soiled lined before exiting resident room and notification of housekeeping to clean and disinfect any potential areas of contamination by soiled linen/trash. On 2/21/23, the Maintenance Director under the supervision of the Regional Vice President initiated an audit of all resident care areas to include but not limited to resident rooms, common areas, shower rooms and hallways. This audit is to identify any areas in need of repair to include but not limited to damaged drywall, damage floor tiles, missing privacy curtains. The Maintenance	

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F 584	Continued From page 7 1b. An observation on 02/23/23 at 9:45 AM revealed a missing privacy curtain in 1 of 4 shower rooms (300-Hall). And without the shower curtain in place, residents showering would be exposed to anyone in the adjacent shower cubical (which had a shower curtain), as well as to anyone opening the hallway door. 1c. An observation and follow-up interview on 02/23/23 at 9:45 AM with the MD revealed multiple one to two inch broken or missing floor tiles next to shower drain in 1 of 4 shower rooms (100-Hall). MD said over time water would seep-down through the missing or cracked tile, next to the drain, causing significant drywall damage, just like the drywall damaged by water in the closed off shower room, which they were still in the process of replacing the tile and drywall damaged by water seepage through broken and missing tile by the drain. A tour of the remaining 2 of 4 shower rooms (100-Hall and 300-Hall) revealed a missing privacy curtain in 1 of 4 shower rooms (300-Hall), revealed without the shower curtain in place, residents showering would be exposed to anyone in the adjacent shower cubical (which had a shower curtain), as well as to anyone opening the hallway door. The MD he followed-up on work orders placed in the electronic work order system (TELS) which was their building management platform disigned for senior living, and maintenance solutions. He stated he checked TELS work orders every morning, and added facility repairs when he had time. He stated he priortized work order requests based on resident safety concerns. He said none of the facility work orders in TELS were about facility repairs or drywall, only things like call bell repairs, wheelchair repairs, broken or clogged	F 584	Director will address all concerns identified during the audit to include initiating repairs and notification of the Administrator of concerns identified. Audit will be completed by 4/3/23. On 3/16/23, the Activities Director, Social Worker, and Medical Record Director initiated an audit of all resident care areas to include but not limited to resident rooms, common areas, shower rooms and hallways. This audit is to ensure all areas to include floors are cleaned and disinfected timely when potentially exposed to contaminated items such as soiled linen/trash or bodily fluids to include but not limited to urine or feces. The Housekeeping Supervisor will address all concerns identified during the audit to include cleaning and disinfecting all areas of concern identified during the audit. Audit will be completed by 4/3/23. On 3/16/23, the Director of Nursing initiated an in-service with the maintenance director and maintenance staff regarding Homelike Environment with emphasis on ensuring rooms remain in good repair and reviewing TELS at least 5 days per week to ensure all maintenance items identified are addressed timely. In-service will be completed by 4/3/23. All newly hired maintenance staff will be educated during orientation regarding Homelike Environment. On 3/16/23, the Staff Development Coordinator initiated in-service with all	

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F 584	Continued From page 8 toilets, etc. He said, most of the facility, repairs he did after work or on the weekends. An interview was conducted with the Administrator on 02/21/23 at 11:35 AM. The Administrator stated it was her expectation for all the residents to have a safe and homelike environment that was in good repair, and that she was aware that the facility utilized the TELS electronic work order system and knew as well that there were a number of resident rooms with drywall damage that still needed repair, and were not homelike. An interview interview was conducted with the Regional Vice President (RVP) on 02/23/23 at 12:40 PM. He stated they identified during the survey period new areas of concern, which they identified during their own tour of the facility's shower rooms and resident rooms, which included: completing all 19-outstanding maintenance work orders, repair and paint damaged drywall in resident rooms, replace or repair broken tile in the shower rooms, and repair or replace any other identified physical physical plant concerns during the renovation. The RVP stated it was his expectation for all the residents to have a safe and homelike environment that was clean and in good repair. 2a. A review of the facility's "bloodborne pathogens policy" revealed how staff protect themselves from blood borne pathogens exposure by using all proper personal protection equipment (PPE), wear gloves, use new gloves in every room, wash/use gel on hands after using gloves, and disinfect after facility nursing staff had cleaned up blood spills/bodily fluid spills.	F 584	staff on (1) placing work orders in TELS to ensure proper notification of maintenance regarding needed repairs (2) Infection control with emphasis on bagging all soiled linen and trash before removing from resident room and timely process for cleaning contaminated areas to include notification of housekeeping to clean and disinfect any areas exposed to soiled linen/trash and/or bodily fluids to include but not limited to urine or feces. In-service will be completed by 4/3/23. After 4/3/23, any staff who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired employees will be in-serviced during orientation. The Activity Director, Social Worker and Medical Records will audit all areas of facility to include resident rooms 101, 104, 114, 116, 203, 214, 217, 303, 815, 817, resident care areas, privacy curtain and 300 hall shower rooms weekly x4 weeks then monthly x1 month utilizing the Home-Like Environment Audit Tool. This audit is to ensure rooms are in good repair to maintain a safe homelike environment. Work orders will be placed in TELS and maintenance will correct any issues identified during the audit. The Administrator will review the Home-Like Environment Audit Tool weekly x4 weeks then monthly x1 month to ensure all concerns were addressed. The Quality Assurance Nurse, Staff Development Coordinator and Unit Facilitator will complete 10 resident care	

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F 584	Continued From page 9 During an environmental round on 02/19/23 at 11:00 AM room 106 was noted to have approximately 2-foot by 3-foot dried brown/black substance on the floor and on resident's bed sheet, which smelled like feces when dampened with water. There was only one resident residing in the room at the time of the observation. A second observation of room 106 occurred on 02/19/23 at 3:50 PM and was noted to still have dried brown/black substance on the floor and on resident's bed sheet. An interview was conducted on 02/19/23 at 4:00 PM with Administrator #1. The Administrator stated the brown/black substance in room might be feces, and he would get nursing to clean it up, then for housekeeping to disinfect the area. The Administrator said the dried soiled area should have been cleaned earlier that day. An interview was conducted on 02/20/23 at 9:15 AM with Nurse #1. Nurse #1 said on 02/19/23 around 4:00 PM she took a wet towel and cleaned up what she described as dry feces on the floor in room 106. She said she first was notified of the feces on room 106's floor on 02/19/23 around 7:30 AM by the third shift night nurse. Nurse #1 said she observed the feces to be dried then. She said she told an aide to clean it up that morning, but they must have forgotten to do it. Nurse #1said housekeeping would follow and disinfect the area, after nursing staff first cleaned it up, being that it was bodily fluids. Nurse #1 stated, 3rd shift nursing staff should have cleaned the area first, and not to have left it for the 1st or 2nd shift nursing staff to take care of.	F 584	audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff bag soiled linen/trash before exiting resident room, timely cleaning, and notification of housekeeping to clean and disinfect any areas potentially exposed to soiled linen/trash or bodily fluids to include but not limited to urine/feces. The Quality Assurance Nurse, Staff Development Coordinator and Unit Facilitator will address all concerns identified during the audit to include cleaning all areas of concern and/or re-training of staff. The Director of Nursing will review the resident care audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the results of the Home-Like Environment Audit Tool and Resident Care Audits to the Quality Assurance Committee monthly x 2 months. The Quality Assurance Committee will meet monthly x 2 months and review the Home-Like Environment Audit Tool and Resident Care Audits to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 584	Continued From page 10	F 584		

An interview was conducted on 02/20/23 at 9:30 AM with Nursing Aide (NA) #2. NA #2 said she worked the 7:00 AM to 3:00 PM shift on the 100-hall. She said she did not work on 02/19/23, but if she did, she would have cleaned up the feces on room 106's floor, and then she would have contacted housekeeping to come clean and sanitize the area. NA #2 said she knew it was feces because the resident in room 106 had a history of defecating on the floor. She said if he did not get his way, or got angry about something, he would yell or scream, or defecate on the floor.

An interview was conducted on 02/21/23 at 8:25 AM with Administrator #2. Administrator #2 said room 106's floor should have been cleaned up by the nursing staff, then mopped and disinfected by housekeeping prior to 4:00 PM on 02/19/23. She said there were no excuses for that dried brown/black substance (feces) to be left there and not cleaned up appropriately.

2b. An observation on 02/21/23 at 11:25 AM revealed Nursing Aide (NA) #3 exited Room 106 carrying an unbagged bundle of soiled linen which consisted of bath towels and washcloths, which appeared to be wet, one bundle in each hand. The NA was observed to be walking toward a linen hamper about 15 feet away from the door to the room from which she exited. The NA made it about halfway when she dropped an uncounted number of washcloths which appeared to be soiled as evidenced by the presence of brown marks on them onto the linoleum floor halfway down the hall, prior to reaching the soiled linen container. The NA then picked up the soiled linen which she had dropped and proceeded to place the soiled linen in the laundry bin. The NA was then observed to leave the hall and the

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observation continued until 11:30 AM and no staff were observed to come to the area where the soiled linens were dropped to clean or sanitize the floor.

An interview was conducted on 02/21/23 at 11:30 AM with NA #3. NA #3 revealed it was only her 2nd day as an NA and that she did not realize she needed to bag soiled linen or get housekeeping to mop and sanitize the area where she dropped the soiled linen. She explained, she did not bag soiled lined at her previous job and was still in training. She also stated she could not remember if she was ever trained on infection control.

A review of facility document titled, "Transcript for Nursing Aide (NA) #3" dated indicated: NA #3 received training on "Principle bloodborne pathogen and biomedical waste management" and completed "Principal infection control training" on 02/15/23 as evidenced by her initialing the document.

An interview was conducted on 02/21/23 at 11:35 AM. Administrator #2. She stated it was her expectation that all staff fully follow all the facility's infection control policies, and that immediately after NA #3 dropped soiled linen in the hallway, she should have notified housekeeping to mop and disinfect the soiled area.

An interview was conducted on 02/21/23 at 11:45 AM. Director of Nursing (DON). He stated NA #3 should have bagged soiled linen, prior to leaving Room 106. He stated NA should have notified housekeeping immediately after the soiled linen spill to come mop and sanitize the area of the spill.

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F 641	Continued From page 12	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 31 residents reviewed for MDS accuracy (Resident #127). Findings included: Resident #127 was admitted to the facility on 10/04/2022 with diagnoses to include rheumatoid arthritis and weakness. Review Resident #127's admission Minimum Data Set (MDS) assessment dated 10/10/2022 revealed tobacco use was coded as no. Review of Resident 127's care plan revealed a plan of care for Safe and Independent Smoker was added on 02/19/2023. An interview and observation of Resident #127 smoking outside in the designated area occurred on 02/21/2023 at 01:25 PM. Resident #127 stated that she has been smoking since she was admitted to the facility in October. She further stated that she kept her cigarettes and lighter in her purse and the facility had never her asked her to turn her cigarettes in for safe keeping. An interview was conducted with the MDS Coordinator #1 on 02/23/2023 at 09:15 A.M. MDS Coordinator #1 stated that the smoking care plan	F 641	F 641 Accuracy of Assessments On 2/23/23, the Minimum Data Set Nurse (MDS) completed a modification of resident #127 admission assessment section “J1300” regarding resident use of tobacco. On 3/16/23, The Consultant initiated an audit of section “J” for all residents’ most current Minimum Data Set (MDS) admission and/or annual assessment to ensure all MDS assessments completed are coded accurately for tobacco use. The MDS nurse completed modifications for all concerns identified during the audit. Audit will be completed by 4/3/23. On 3/16/23, the Director of Nursing initiated an in-service with the MDS Coordinator and MDS Nurse regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation regarding MDS Assessments and Coding. 10% audit of all residents to include	4/3/23

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F 641	Continued From page 13 for Resident #127 was initiated on 02/19/2023 after a smoking assessment was completed. She further stated that forgot to update Resident #127's MDS assessment. An interview was conducted with the Director of Nursing (DON) on 02/23/2023 at 11:55 A.M. The Director of Nursing stated he expected to MDS assessments to be accurate.	F 641	resident #127 most recent MDS admission and annual assessments section “J”, will be completed by the Director of Nursing (DON) and/or MDS Consultant utilizing the MDS Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment to include section “J” for use of tobacco. The MDS Coordinator and DON will address all areas of concern identified during the audit to include retraining of the MDS nurse and completing necessary assessment of the resident. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed The DON will forward the results of MDS Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the MDS Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		4/3/23

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medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 15 Based on observation, record review and staff interviews the facility failed to develop and implement a comprehensive person-centered care plan that addressed measurable goals and interventions for 4 of 6 residents (#8, #77 #123, #127) reviewed for care planning. Findings included: 1). Resident #8 was admitted to the facility on 11/23/22 with diagnoses which included in part: congestive heart failure, anxiety, depression, and dementia with behaviors. Resident #8's 12/25/22 admission Minimum Data Set (MDS) revealed resident with severe cognitive impairment, was sometimes able to make self understood and usually understands others. Resident #8 had the following behaviors coded: physical behaviors, other behavioral symptoms, behavioral symptoms which significantly interfered with care, put others at risk of physical injury, intruded on privacy or activities of others, significantly disrupted the care or living environment, and rejection of care. Resident #8 was coded as had one fall since admission and received antipsychotic, antidepressant, and diuretic medications. Resident #8's MDS assessment revealed the following Care Area Assessments (CAAs) were to be addressed: cognition, communication, incontinence, behavior, falls, nutrition, dehydration, pressure ulcers and psychotropic medication. Resident #8's MDS indicated on 12/29/22 decision was made to address each of the CAA areas in the care plan. Review of Resident #8's 1/10/23 care plan	F 656	F 656 Develop/Implement Comprehensive Care Plan Resident #8 no longer resides in the facility. On 2/23/23, the MDS nurse updated resident #77 care plan regarding vision, incontinence, psychosocial and mood. On 3/17/23, the MDS nurse updated resident #123 care plan regarding psychosocial and falls. On 3/17/23, the MDS nurse reviewed resident #127 care plan regarding smoking supervision and tobacco use. Resident is care planned appropriately for “safe, independent smoking” On 3/16/23, the facility consultant initiated an audit of all residents most recent comprehensive assessment to include resident #77, #123, and #127. This audit is to ensure all CAA were completed and care plan updated for CAA identified. The MDS nurse will address all concerns identified during the audit to include modification of assessment and updating care plans for all concerns identified. Audit will be completed by 4/3/23. On 3/16/23, the Minimum Data Set Nurse (MDS) initiated an audit of all residents who smoke or utilize tobacco products. This audit is to ensure residents are care planned appropriately for tobacco use and/or smoking supervision. The MDS nurse will address all concerns identified	

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F 656	Continued From page 16 revealed the following triggered CAA areas were not addressed: communication, incontinence, dehydration.and falls. Interview on 2/23/23 at 9:55 AM with MDS Coordinator #1 revealed she had been in the position since August 2022. MDS Coordinator #1 stated the CAAs were used to determine areas to be care planned. MDS Coordinator #1 stated interventions in the care plan went into the care guide, a tool used by the nursing assistants to know a resident's care needs. MDS Coordinator #1 stated she tried to check to make sure the areas selected in the CAAs were included in the care plan, but she must have missed including communication, incontinence, dehydration and falls in Resident #8's care plan. Interview on 2/23/23 at 2:34 PM with the Director of Nursing (DON) revealed MDS Coordinator #1 was new to the position and was still learning the Resident Assessment Instrument (RAI) process. DON stated he expected care plans were accurate, reflected the resident's current condition and included areas addressed in the CAA's. 2). Resident #77 was admitted to the facility with diagnoses which included in part acute deep vein thrombosis, diabetes with hyperglycemia, and blindness. Resident #77's 1/30/23 admission MDS revealed resident was cognitively intact, had impaired vision, required assistance with bed mobility, transfers, eating and toileting, was frequently incontinent of bowel and bladder and had one fall since admission. Resident #77's MDS indicated resident had little interest or pleasure in doing	F 656	during the audit to include updating care plans for all concerns identified. Audit will be completed by 4/3/23. On 3/17/23, the Director of Nursing completed an in-service with all MDS nurses regarding completion of CAA during MDS assessments with emphasis on ensuring resident care plan is updated for all CAA identified during the assessment to include but not limited to communication, incontinence, dehydration, falls, vision, psychosocial and mood. All newly hired MDS nurses will receive the in-service during orientation. On 3/16/23, the Staff Development Coordinator initiated an in-service with all nurses regarding Care Plans with emphasis on ensuring care plans are person centered with measurable goals and interventions and that care plans are updated timely when there are changes in any aspect of care to include but not limited to medical diagnoses, ADL needs, safety interventions, smoke safety, vision needs, communication deficits, incontinence, dehydration, psychosocial and mood. The in-service will be completed by 4/3/23. After 4/3/23, any nurse who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired nurses will receive the in-service during orientation. 10% of all residents most recent comprehensive MDS assessment to	

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things, was feeling down and had thoughts of being better off dead.

Resident#77's 1/30/23 admission MDS assessment indicated the following Care Area Assessments (CAAs) were addressed with the decision to proceed to care plan: vision, activities of daily living, incontinence, psychosocial, mood, activities, falls, nutrition, and pressure ulcer.

Resident #77's 2/6/23 care plan revealed the following CAA areas were not addressed: vision, incontinence, psychosocial and mood. Falls was added to the care plan on 2/20/23.

Review of Resident #77's medical record revealed resident sustained falls on 1/29/23 and 2/6/23.

Interview on 2/23/23 at 9:49 AM with the MDS Coordinator #1 revealed that she had been in the position since August and was still learning the MDS process. MDS Coordinator #1 stated falls as well as the other areas addressed in the CAAs should have been care planned for Resident #77. MDS Coordinator #1 stated falls focus was not entered into Resident #77's care plan until 2/20/23. MDS Coordinator stated that the areas that triggered CAAs including vision, psychosocial, mood and pressure ulcers should have been care planned.

Interview on 2/23/23 at 1:36 PM with Social Worker (SW) #1revealed when a resident had mood and behavior indicators a Care Area Assessment (CAA) was triggered to determine decision to care plan that area. SW#1 stated after she completed the CAA, she put interventions in the care plan. SW #1 stated that

include residents #77, #123, and #127 will be reviewed by the MDS Consultant and/or Director of Nursing weekly x 4 weeks then monthly x 1 month. This audit is to ensure all CAA were completed and care plan updated for CAA identified. The MDS nurse and/or Director of Nursing will address all concerns identified during the audit to include modification of assessment and updating care plans for all concerns identified. The Director of Nursing (DON) will review and initial the MDS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed.

The Quality Assurance Nurse (QA) will review all newly admitted residents who smoke or desire to smoke weekly x 4 weeks then monthly x 1 month utilizing Smoking Audit Tool. This audit is to ensure residents were assessed for smoking safety, MDS admission assessment is coded for tobacco use and care plan updated for smoking supervision indicated. The QA nurse will address all concerns identified during the audit to include assessment of the resident, updating MDS assessment and care plan when indicated. The DON will review the Smoking Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The DON will forward the results of the MDS Audit Tool and Smoking Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will

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psychosocial and mood should have been addressed in Resident #77's care plan as he made statements that he was depressed daily, had loss of pleasure and interest, had been feeling down and had thoughts of being better off dead. SW#1 reviewed Resident #77's care plan and stated psychosocial and mood focus was missed.

Interview on 2/23/23 at 2:34 PM with the Director of Nursing (DON) revealed MDS Coordinator #1 was new to the position and was still learning the Resident Assessment Instrument (RAI) process. DON stated he expected care plans were accurate, reflected the resident's current condition and included areas addressed in the CAA's.

3). Resident #123 was admitted on 10/28/22 with diagnoses which included in part motor vehicle accident with spinal cord injury resulting in paraplegia, Stage 4 sacral decubitus, and major depression.

Resident #123's 11/3/22 admission Minimum Data Set (MDS) revealed resident was cognitively intact. MDS indicated Resident #123 required extensive assistance with bed mobility and eating, total dependence with toileting and did not transfer. Resident #123 had a stage 4 pressure ulcer which was present on admission. MDS indicated resident had a catheter, was incontinent of bowel, received an antidepressant daily and had little interest or pleasure in doing things, feeling down, trouble sleeping and poor appetite.

The following Care Area Assessments (CAAs) were noted on the 12/7/22 summary as proceed to care plan: activities of daily living,

meet monthly x 2 months to review the MDS Audit Tool and Smoking Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.

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incontinence, psychosocial, activities, falls, nutrition, pressure ulcer and psychotropic medication.

Resident #123's 12/1/22 care plan revealed the CAA areas psychosocial and falls were not addressed.

Interview on 2/23/23 at 9:49 AM with the MDS Coordinator #1 revealed that she had been in the position since August and was still learning the MDS process. MDS Coordinator #1 stated the areas that triggered CAAs and were listed as proceed to care plan should have been care planned. MDS Nurse stated she expected psychosocial would be addressed in Resident #123's care plan.

Interview on 2/23/23 at 1:36 PM with SW#1 revealed Resident #123 had mood indicators including loss of interest in doing things, loss of appetite, trouble sleeping and feeling down and these areas should have been addressed in the care plan.

Interview on 2/23/23 at 2:16 PM with Director of Nursing revealed he expected care plans would be up to date and address the care areas. Care plans should be accurate and reflect the resident's current condition.

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4. Resident #127 was admitted to the facility on 10/04/2023 with diagnoses to include rheumatoid arthritis and weakness.

Review of the admission Minimum Data Set (MDS) assessment date 10/10/2022 revealed Resident #127 was coded as no for tobacco use.

Resident #127 was not on the list of smokers provided by the facility upon entrance 02/19/2023.

Resident #127 was observed sitting in the smoking area smoking a cigarette on 02/19/2023 at 12:47 P.M.

Review of the care plan for Resident #127 revealed a plan of care for smoking was initiated on 02/19/2023, and listed Resident #127 as a safe and independent smoker. Prior to 02/19/2023 there was no care plan that addressed smoking for Resident #127.

An observation and interview of Resident #127 smoking in the smoking area outside occurred on 02/21/2023 at 01:25 P.M. Resident #127 stated that she had been smoking in the facility since she was admitted in October. She further stated that no one had ever asked her to turn her cigarettes and lighter in for safe keeping at the facility.

An interview was completed with Nurse #9 on 02/22/2023 at 11:05 A.M. Nurse #9 stated that she had only worked at the facility for a few weeks and was still learning the residents. She

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F 656	Continued From page 21 further stated that she was aware that Resident #127 was a smoker. An interview was conducted with MDS Coordinator #1 on 02/23/2023 at 09:15 A.M. MDS Coordinator #1 stated that the plan of care for safe and independent smoker was initiated for Resident #127 on 02/19/2023. She further stated that is when she found out Resident #127 was a smoker. MDS Coordinator #1 stated that since she didn't work the floor, the only way she knew if a resident smoked or not was when the smoking assessment was completed. She explained there was no smoking assessment completed for Resident #127 prior to 02/19/2022. She indicated that she initiated plan of care for smoking as soon as she found out Resident #127 was a smoker. MDS Coordinator #1 stated that when the facility became aware that a surveyor was observing the smoking area on 02/19/2023, a smoking audit was completed on all the residents in the facility. She further stated that was when she became aware Resident #127 was a smoker. An interview was completed with the Director of Nursing (DON) on 02/23/2023 at 11:55 A.M. The DON stated that the care plan should be resident centered and updated in a reasonable time frame. He further stated that MDS Coordinator #1 had initiated the plan of care for smoking as soon as she became aware Resident was a smoker.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		4/3/23

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F 658	Continued From page 22 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Consultant Pharmacist and Nurse Practitioner interviews, the facility failed to order and administer a diabetes medication as prescribed by the physician for 1 of 6 residents reviewed for unnecessary medications (Resident #62). Findings included: Resident #62 was admitted to the facility 10/30/21 with medical diagnosis which included stroke with hemiplegia and diabetes. Resident#62's 11/18/22 quarterly care Minimum Data Set (MDS) revealed resident was cognitively intact, had diagnoses of diabetes and received insulin injections two days during the look back period. Resident #62 exhibited no rejection of care. Resident #62's 11/29/22 care plan revealed a focus of diabetes with potential for complications of hyper/hypoglycemia. Goal was Resident #62 would be free from any signs/symptoms of hyper/hypoglycemia through next review. Interventions included fingerstick blood sugar monitoring and medication as ordered by the physician. Review of the 1/24/23 consultant pharmacist Medication Regimen Review for Resident #62 indicated a recommendation to consider adding Januvia 100 milligrams (mg) daily for diabetes, discontinue Humalog Sliding scale insulin injections, and decrease fingerstick blood sugar checks from four times per day to twice per day	F 658	F 658 Services to Meet Professional Standards On 2/22/23, the physician was notified that order for Ozempic 0.5mg weekly had not been initiated as directed with new order to initiate Ozempic 0.5mg weekly beginning 2/24/23. Resident #62 was assessed with no adverse effects noted. On 3/16/23, the Director of Nursing initiated an audit of all pharmacy recommendations from 11/1/22 to 3/14/23. This audit was to ensure all recommendations were reviewed by the physician and new orders transcribed accurately and timely to the medication administration record (MAR) and administered per physician orders. The Director of Nursing (DON) addressed all concerns identified during the audit to include but not limited to assessment of the resident, notification of the physician for further recommendations and/or clarification of orders and initiating new orders when indicated. The audit will be completed by 4/3/23. On 2/23/23, the Director of Nursing (DON) initiated an in-service with all nurses regarding (1) Pharmacy Recommendations with emphasis on ensuring recommendations are reviewed by the physician timely and all new orders transcribed accurately and administered	

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F 658	Continued From page 23 before breakfast and at bedtime. The physician checked disagree with recommendations and wrote an order on the top portion of the medication regimen review form for Ozempic 0.5 mg give subcutaneously weekly. The form was signed by the physician and dated 2/4/23. There was no notation on the form that a nurse had reviewed or implemented the order. Review of the medication administration record (MAR) for Resident #62 for February 2023 revealed Ozempic 0.5 mg subcutaneous weekly was not listed. Review of the physician orders in the electronic health record for Resident #62 revealed the order for Ozempic written by the physician on 2/4/23 had not been entered. Interview on 2/21/23 at 3:00 PM with Unit Manager #1 revealed she had been in the position since October 2022. Unit Manager #1 stated the pharmacy recommendations were sent to the Director of Nursing (DON) who then sent them to Unit Manager #1 and Unit Manager #2. Unit Manager #1 stated she was responsible for all the Pharmacy Recommendations. Unit Manager #1 stated she gave the recommendations to Medical Records to send to the providers for review and approval. Once reviewed and signed by the provider, medical records returned the recommendations to the DON or Unit Manager #1. If there was a new order to be implemented, Unit Manager #1 stated she faxed it to the pharmacy and entered it into the electronic medical record. Unit Manager #1 stated she was not scheduled to work on 2/4/23 when the order for Ozempic for Resident #62 was received. Unit Manager #2 was responsible for	F 658	per physician orders utilizing a two-nurse check system. In-services will be completed by 4/3/23. After 4/3/23, any nurse who has not worked or received the in-services will complete in-service prior to the next scheduled work shift. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation regarding Pharmacy recommendations. The Minimum Data Set Nurse (MDS) will review all pharmacy recommendations monthly x 2 months. This audit is to ensure all recommendations were reviewed by the physician and new orders transcribed accurately and timely to the medication administration record (MAR) and administered per physician orders. The MDS nurse will address all concerns identified during the audit to include notification of physician for further recommendations, assessment of resident, initiating orders when indicated and/or retraining of staff. The Director of Nursing (DON) will review the pharmacy recommendation audit monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Pharmacy Recommendation Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months to review the Pharmacy Recommendation Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 658	Continued From page 24	F 658		

transcribing the orders from the pharmacy recommendations in Unit Manager #1's absence.

Interview on 2/21/23 at 3:11 PM with Unit Manager #2 revealed the DON received the pharmacy recommendations and Medical Records gave the recommendations to the provider for review and signature. Once signed the recommendations were returned to the unit managers to implement the orders. Unit Manager #2 reviewed Medication Administration Record for Resident #62 and verified the order for Ozempic for Resident #62 was not implemented. Unit Manager #2 did not recall seeing the pharmacy recommendation for Resident #62 and did not know if Unit Manager #1 had been off when the recommendation was received. Unit Manager #2 indicated she was responsible for transcribing the orders from the pharmacy recommendations in Unit Manager #1's absence.

Interview on 2/22/23 at 9:41 AM with the Nurse Practitioner (NP) revealed the pharmacy recommendations were put on the desk in the office for her to review and address. NP stated that after she reviewed and addressed the pharmacy recommendations, the nurses were expected to enter the orders in the computer as written. NP stated that she expected pharmacy recommendations and any other physician orders were implemented as soon as possible after written. NP further stated a delay in implementing orders could result in a delay in obtaining a desired effect for a resident. In this case, a delay in initiating the Ozempic order was not a significant medication error, but it resulted in a delay in obtaining better glycemic control and reduction in blood glucose testing for Resident #62.

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F 658	Continued From page 25 Interview on 2/22/23 at 11:15 AM with the Consultant Pharmacist revealed the medication Ozempic was used as an adjunct therapy for diabetic glycemic control. The Consultant Pharmacist indicated a delay in initiating a physician order would result in a delay in achieving desired results. The pharmacist stated from a professional standpoint, she expected the facility would initiate physician orders as soon as possible after written. Interview on 2/22/23 at 4:00 PM with the DON revealed he expected pharmacy recommendations were addressed as soon as possible and orders from the recommendations were transcribed when received. Unit Manager #1 received the signed physician recommendations and was to transcribe the new orders written on the forms as soon as possible. Unit Manager #2 was responsible in Unit Manager #1's absence. The original copy of the pharmacy recommendation was sent to medical records to scan into the electronic medical record. There was not a process in place to check that all orders were transcribed prior to the recommendation form being scanned into the record. DON stated he was not aware that the 2/4/23 signed order for Ozempic for Resident #62 was not implemented and that he might need implement a system to ensure recommendations were addressed, and orders were transcribed timely.	F 658		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		4/3/23

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F 687	Continued From page 26 and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident, staff, and physician interviews the facility failed to follow up on a Podiatrist (foot doctor) order from June 2022 for diabetic shoes to help with protecting the resident's feet secondary to loss of sensation, weakness, and deformity which caused the resident frustration and the inability for the resident to get out of his room and ambulate with his walker for 1 of 1 resident (Resident #36) reviewed for diabetic foot care. Findings included: Resident #36 was admitted to the facility on 05/08/17 with diagnoses to include diabetes mellitus with diabetic polyneuropathy (numbness, pain, burning in feet due to peripheral nerve damage), depression, and generalized anxiety disorder. Review of the electronic medical record (EMR) for Resident #36 revealed a Podiatrist exam report dated and signed on 06/20/2022. The report read in part, "Reason for Visit: Diabetic foot care. Patient presents for at risk foot care. Patient footwear evaluation was performed. Order written for diabetic shoes secondary to loss of protective	F 687	F 687 Foot Care On 3/13/23, the therapist assessed resident #36 for proper fitting of current diabetic shoes. Shoes were found to fit properly and resident #36 was able to ambulate with restorative aide without difficulty. On 3/14/23, the treatment nurse assessed bilateral feet for resident #36 with no identified skin concerns. On 3/14/23, new diabetic shoes were received for resident #36. On 3/17/23, the Director of Nursing audited all diabetic residents to include resident #36. This audit is to identify any resident utilizing diabetic shoes to ensure shoes fit appropriately and to ensure any orders for diabetic shoes were obtained timely. The Director of Nursing will address all concerns identified during the audit. Audit will be completed by 4/3/23. On 3/17/23, the Quality Assurance Nurse	

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F 687	Continued From page 27 sensation-with weakness, deformity, pre-ulcer callous but no history of ulceration. Follow-up: Diabetic Foot established patient exam in 2-3 months. The patient is receiving care pursuant to an order from the Primary Care Physician. Upon Primary Care Physician's review of the most current consult note and plan of care, should the Primary Care Physician not agree with medical necessity of both the care delivered and the proposed plan of care, Podiatrist is to be notified immediately." Review of the EMR revealed an order written by the Podiatrist on 06/20/2022 to have DME (durable medical equipment) Vendor or PT (physical therapy) department, measure for, order and dispense diabetic shoes and 3 pairs of heat molded/custom molded diabetic insoles. Review of a follow-up Podiatrist exam report dated 10/31/2022 read in part, "Reason for Visit: Patient presents for diabetic foot care. Patient presents for at risk foot care. Footwear evaluation was performed. Patient was counseled on proper footwear. Details: Good diabetic footwear needed; order written for shoe. Follow up: Diabetic Foot established patient exam in 2-3 months. The patient is receiving care pursuant to an order from the Primary Care Physician. Upon Primary Care Physician's review of the most current consult note and plan of care, should the Primary Care Physician not agree with the medical necessity of both the care delivered and the proposed plan of care, Podiatrist is to be notified immediately. Review of a telemedicine Psychotherapy Progress note dated 11/04/22 revealed in part, "He is frustrated about not yet having diabetic	F 687	(QA), Medical Records staff and appointment scheduler initiated an audit of all consult visits for the past 60 days. This audit is to ensure all newly written orders/recommendations following a consult visit were initiated per physician order and/or the physician notified if order cannot be completed timely for further recommendations with documentation in electronic record. The QA nurse and RN Supervisor will address all concerns identified during the audit to include initiating orders when indicated and/or notification of the physician when order cannot be completed timely for further recommendations. The audit will be completed by 4/3/23. On 3/16/23, the Staff Development Coordinator initiated an in-service with all nurses regarding Following Physician Orders with emphasis on ensuring orders for specialty items to include but not limited to diabetic footwear are initiated/obtained timely and/or physician notified when order cannot be completed timely for further recommendations. In-services will be completed by 4/3/23. After 4/3/23, any nurse who has not worked or received the in-service will complete this in-service prior to next scheduled work shift. All newly hired nurses will receive the in-service by the Staff Facilitator during orientation. The QA nurse will audit 10% of all consult visits weekly x 4 weeks then monthly x 1 month utilizing the Consult Audit Tool. This audit is to ensure all newly written orders/	

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F 687	Continued From page 28 shoes after going to the store to get these. The writer stated that sometimes it takes a week or two to make a shoe and he will have them soon." Review of the quarterly Minimum Data Set (MDS) assessment dated 12/30/2022 revealed Resident #36 was cognitively intact. Review of Resident #36's care plan updated on 12/30/2022 listed the following intervention for care to prevent falls: Resident to wear proper and non-slip footwear. Review of a telemedicine Psychotherapy Progress note dated 01/06/23 read in part, "He complains about neuropathy symptoms and how this creates some limitations to his abilities, and it is frequently painful." Review of Resident #36's EMR revealed a nurse's health status note written by Nurse Practitioner #1 dated 01/20/2023 which read: Patient was seen and it was determined that orthopedic shoes would benefit patient. Review of a grievance made by Resident #36 dated 01/26/2023 read in part, "Wants information about his diabetic shoes states it's been since Oct. and 2 different MDs supposed to be ordering his shoes." The written grievance response by the Grievance Official/Director of Nursing (DON) dated 01/27/2023 read in part, "After an appropriate investigation supervised by the Grievance Official which included appropriate interviews ... the diabetic shoes are pending the physician's examination and documentation of need." An interview was conducted with Resident #36 on 02/19/2023 at 12:37 P.M. Resident #36 stated	F 687	recommendations following a consult visit were initiated per physician order and/or the physician notified if order cannot be completed timely for further recommendations with documentation in electronic record. The QA nurse will address all concerns identified during the audit to include initiating orders when indicated and/or notification of the physician when order cannot be completed timely for further recommendations. The Director of Nursing will review the Consult Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Consult Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months to review the Consult Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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that he was a diabetic and was supposed to have a new pair of diabetic shoes that were ordered by the Podiatrist in June 2022. He further stated that he used to ambulate with his walker and get out of his room more, but he was unable to do that anymore because he did not have his diabetic shoes. Resident #36 stated that he could no longer wear his old diabetic shoes because they were stretched out and did not fit properly. He indicated even though he was wearing the blue non-skid socks provided by the facility, he did not feel they provided enough protection for his feet or support when ambulating. Resident #36 stated he was always very careful with his feet because he had neuropathy which could lead to sores or loss of his foot or leg. Resident #36 further stated that he had complained to everyone about not getting his shoes. He stated 8 months was too long to wait for new diabetic shoes.

An observation of Resident #36's old pair of diabetic shoes with orthotic insoles occurred with him on 02/19/2023 at 12:47 P.M. He stated that the shoes were stretched out and the heels no longer fit properly and rubbed on his foot.

An interview was completed with the DON on 02/21/2023 at 11:35 A.M The DON stated that he became the DON in August 2022, and he didn't know why the shoes were not ordered in June 2022. The DON stated the Activities Director was the staff member who had received and investigated the grievance filed by Resident #36 regarding his diabetic shoes. He further stated that Social Worker (SW) #1 was the staff member that had been in communication with the physicians and the DME vendor. The DON indicated that the facility had a change in Medical Directors in October of 2022. He stated the facility

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had an interim Medical Director from October 2022 until December 2022 when the current Medical Director began working with the facility. The DON stated that he felt these changes had contributed to the delay in getting the diabetic shoes for Resident #36.

An interview with the Activities Director occurred on 02/21/23 at 02:26 P.M. The Activities Director stated she had assisted Resident #36 with filling out the facility grievance form requesting information about his diabetic shoes. The Activities Director stated that the information regarding Resident #36's diabetic shoes was obtained from SW #1.

An interview was conducted with Quality Improvement Nurse (QI) #1 on 02/21/23 at 03:32 P.M. QI Nurse #1 stated that she was not involved in getting Resident #36 his diabetic shoes. She further stated that physical therapy or the social worker would have that information.

An interview was completed with SW #1 on 02/22/2023 at 09:45 A.M. SW #1 stated that she had been dealing with the DME Provider for months trying to get Resident #36's diabetic shoes. She further stated that she has been waiting to receive the appropriate documentation from the Physician to move forward with getting the shoes ordered. SW #1 indicated that the DME Vendor required the documentation be provided by a MD (Doctor of Medicine) or a DO (Doctor of Osteopathy), not a podiatrist or nurse practitioner (NP). SW #1 stated that she had asked the Medical Directors to provide the required documentation, but it had not been done yet. SW #1 further stated that 8 months was not a reasonable length of time for someone to have to

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wait to receive their diabetic shoes.

An interview was completed with the Medical Director #2 on 02/22/2023 at 10:10 A.M. Medical Director #2 stated that he became the facility Medical Director in December 2022. He further stated that he had never been provided with any paperwork from the DME Vendor regarding the required documentation for Resident #36's diabetic shoes. He further stated that the Social Worker had asked him to write an order for the resident to see a Podiatrist for diabetic shoes and he had written the order on 01/03/23. The Medical Director #2 stated that Resident #36 was diabetic and had poor circulation in his feet and legs. He indicated that Resident #36 was at risk for diabetic foot ulcers and needed the diabetic shoes for skin protection and for safe ambulation. The Medical Director #2 stated that 8 months was an unreasonable amount of time for a diabetic resident to have to wait to get new diabetic shoes. He further stated he would provide the documentation needed by the DME Vendor in the chart today.

An interview was completed with the DON on 02/23/2023 at 11:55 A.M. The DON stated that he had not personally been involved in the process of obtaining the necessary paperwork to get Resident #36 his diabetic shoes. He further stated that he felt the facility had made multiple efforts in the last 8 months to obtain diabetic shoes for Resident #36. The DON indicated that the delay was related to the turnover in medical directors and the DME Vendor. He stated that he did not think 8 months was a reasonable timeframe for Resident #36 to wait for new diabetic shoes.

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F 687	Continued From page 32 An interview was conducted with Administrator #2 on 02/23/2023 at 11:20 A.M. Administrator #2 stated that she was the Fill-In Administrator because the facility's Administrator was on vacation. She further stated that she did not know Resident #36 but that her expectation for residents that are diabetic is that they should receive the appropriate footwear to prevent diabetes complications. Administrator #2 indicated that 8 months was not a reasonable time frame for a resident to have to wait for new diabetic shoes.	F 687		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and physician interviews the facility failed to: 1) comprehensively assess residents for fall risk, thoroughly investigate falls and implement interventions to reduce the risk of falls for residents with a history of falls for 2 of 2 residents (Resident #8 and Resident #77) reviewed for falls; 2) ensure Resident #22, who was assessed as an unsafe smoker, had interventions implemented for safe smoking to include nursing staff to assist the resident to the designated smoking area, not leaving the resident unattended while smoking, and the use of a	F 689	F 689 Free of Accidents Resident #8 no longer resides in the facility. On 3/16/23, the Quality Assurance Nurse (QA) completed a falls risk assessment for resident #77 and reviewed all falls to ensure each fall was thoroughly investigated and appropriate safety interventions implemented to reduce the risk of falls, care plan updated per facility protocol and safety interventions were in	4/3/23

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smoking apron; 3) secure smoking materials (Residents #22, #104, and #127); and 4) assess the safety of a resident who was a known smoker (Resident #127) for 3 of 4 residents reviewed for smoking.

Findings included:

1). Resident #8 was admitted to the facility on 11/23/22 with diagnoses which included in part dementia with behaviors.

Resident #8's 11/23/22 Admission Fall Risk Evaluation was incomplete with predisposing diseases, medications, cognition, vision, and continence questions not answered. Evaluation indicated no follow up required.

Minimum Data Set (MDS) assessment on 12/5/22 revealed Resident was discharged to the hospital with return anticipated.

MDS assessment on 12/19/22 revealed Resident #8 was readmitted following hospitalization.

A Falls Risk Evaluation completed on 12/19/22 indicated resident did not exhibit behaviors, was not at risk of falls and no follow up was required.

Nursing progress note on 12/20/22 at 11:45 PM revealed Resident #8 was found lying on the floor on the right side with the bed in the lowest position. Immediate action taken following the fall revealed floor mat was placed at bedside.

Incident report completed by Nurse #2 on 12/20/22 at 11:45 PM revealed there were no predisposing environmental, physiological, or situational factors that contributed to Resident

place per plan of care.

On 3/14/23, the Quality Assurance Nurse assessed resident #22 for smoking safety and educated on smoke policy to include times available for smoking and policy to secure all smoke material at nurse station. Resident #22 identifies as “smoking supervision”. Resident #22 placed on every 15-minute checks due to behavior of smoking without supervision and failure to return smoke material per facility protocol. The care plan was updated for new safety intervention.

On 3/16/23, Quality Assurance Nurse assessed resident #127 for smoking safety and educated on smoke policy to include the policy to secure all smoke material at nurses’ station. Resident verbalized understanding and provided all smoke paraphernalia to the nurse following smoke cession. Resident care plan updated to “smoking supervision.”

On 2/27/23, the RN Supervisor assessed resident #104 for smoking safety and educated on smoke policy to include the policy to secure all smoke material at nurses’ station. Resident #104 refuses to sign policy or provide smoke material to staff upon return from smoke sessions. Resident #104 placed on every 15 minutes checks for safety. Resident #104 care plan updated to “smoking supervision”.

On 3/16/23, the QA nurse and RN supervisor initiated an audit of all

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F 689	Continued From page 34 #8's fall and no root cause was identified. There was no indication of interventions being implemented to address fall risk. Resident #8's 12/25/22 admission Minimum Data Set (MDS) revealed resident had severe cognitive impairment with impaired ability to make self understood and understand others, had behaviors, rejected care, and had one fall since admission with no injury. Resident #8 required extensive assist of 2 people with bed mobility and transfers occurred only once or twice with 2 person assist. Resident #8 was non ambulatory. Resident #8's Care Area Assessment (CAA) summary indicated falls would be addressed in the care plan. Nursing progress note written by the Staff Development Coordinator (SDC) who was assigned to Resident #8 on 1/1/23 at 1:26 PM revealed resident was found sitting on the floor by the bed with no injuries noted. The progress note indicated the bed was in low position but did not indicate if the floor mat (mattress) was present beside the bed. Immediate actions taken included resident was placed back in bed and care was rendered. Incident report completed by the SDC on 1/1/23 at 1:26 PM revealed there were no predisposing environmental, physiological, or situational factors, no witnesses and no root cause identified for Resident #8's fall. There was no indication of interventions being implemented to address fall risk. Interview on 2/23/23 at 9:46 AM with the Staff Development Coordinator (SDC) revealed he was assigned to Resident #8 on 1/1/23 when she fell.	F 689	residents' falls assessments. This audit is to ensure a Falls Risk Assessment is completed on admission, quarterly and with changes, safety interventions are initiated to prevent falls and care plan updated for risk for falls/intervention initiated. The QA nurse and RN supervisor will address all concerns identified during the audit to include assessment of the resident, initiating interventions, and updating care plan when indicated. The audit will be completed by 4/3/23. On 3/16/23, the facility consultant, QA nurse and RN supervisor initiated an audit of all incident reports for the past 30 days. This audit is to ensure all incidents were investigated for root cause with appropriate interventions initiated based on the root cause, resident was assessed following incident, physician /resident representative (MD/RR) notified, care plan/care guide updated for new interventions and investigative folders completed timely with statements and an investigational summary. All areas of concern will be addressed by the QA nurse and RN supervisor to include investigating incident to determine root cause, initiating appropriate interventions based on root cause, notification of MD/RR, updating care plan/care guide with any new interventions and completion of investigative folder. The audit will be completed by 4/3/23. On 3/16/23 the QA nurse, Unit Facilitator and RN supervisor initiated an audit of all	

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F 689	Continued From page 35 SDC did not recall if the floor mat was in place and did not recall implementing any fall prevention interventions following the incident. Multiple attempts to contact NA #4 who was assigned to Resident #8 on 1/1/23 when the resident fell were unsuccessful. Resident #8's 1/10/23 care plan revealed risk of falls, history of falls and fall prevention interventions including the floor mat were not listed. Nursing progress notes on 1/12/23 and 1/13/23 indicated Resident #8 was trying to scoot out of the bed and attempting to get up from the bed. Nursing progress note written by Nurse #2 on 1/15/23 at 12:30 AM revealed Resident #8 was found on the floor face down. Bed was in high position and the floor mat was on the floor but not close to the bed. Progress note indicated Resident #8 had history of moving the floor mat away from the bedside with her feet and used the bed remote to raise the bed to the high position. Following the fall Resident #8 was sent to the emergency room for evaluation and returned to the facility with right eye bruising and swelling and hematoma to the right cheekbone. Progress note indicated a bed mattress was placed beside the bed. Incident report completed by Nurse #2 on 1/15/23 at 12:30 AM indicated Resident #77 was sent to the emergency room due to obvious trauma to the right eye, cheek, and nose. Resident #8 was unable to give a description of the incident. Nurse #2 indicated Resident #8's bed was in the high position, at least waist high, when she	F 689	residents at risk for falls. This audit is to ensure all safety interventions are in place per care plan to prevent falls. The QA nurse, Unit Facilitator and RN supervisor will address all concerns identified during the audit to include ensuring safety interventions are in place per plan of care and education of staff. Audit will be completed by 4/3/23. On 2/20/23, the Director of Nursing (DON) completed an audit of all resident rooms to ensure all residents who smoke had no smoking paraphernalia in the rooms. No smoking materials were found in resident rooms during the audit. On 3/16/23, the Quality Assurance Nurse initiated an audit of all smoking assessments to ensure completion of assessments for residents who smoke or desire to smoke. This audit was to ensure residents were assessed for smoke safety per facility protocol, educated on smoke policy, smoke material secured per facility protocol and care plan updated to accurately reflect smoking status. The Quality Assurance nurse will address all concerns identified during the audit to include assessment of resident, education of the resident, securing smoke paraphernalia when indicated, and updating care plan for smoke supervision indicated. The audit will be completed by 4/3/23. On 3/17/23, the Medical Records Director and Social Worker (SW) initiated	

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F 689	Continued From page 36 entered the room. There was no indication of interventions being implemented to address fall risk and no root cause was identified. Nurse Practitioner (NP) progress note on 1/16/23 indicated Resident #8 was evaluated due to the fall on 1/15/23. NP note revealed Resident #8 had right eye bruising and swelling and right cheek hematoma. NP reviewed the CT (computerized tomography) scan results from the emergency room which indicated Resident #8 had a hematoma to the right cheek and forehead with no evidence of intracranial bleeding. Interview on 2/23/23 at 3:45 PM with Nurse #2 revealed she was assigned to Resident #8 on 12/20/22 and 1/15/23 when resident fell. Nurse #2 stated Resident #8 was a high fall risk with confusion and impaired safety awareness. Nurse #2 stated a floor mat was implemented at some point, but she could not recall when and that at times Resident #8 was able to kick the mat away from the bed. Nurse #2 stated when Resident #8 fell on 1/15/23 she had been in another room providing resident care when she heard a bed being raised. Nurse #2 stated she finished completing care and went to check on Resident #8. Nurse #2 stated when she arrived in Resident #8's room, resident was on the floor face down and the floor mat was on the floor but not near the bed. Nurse #2 indicated she did not initiate new interventions following the fall. Nurse #2 stated the nurse on the floor was able to initiate interventions, but it was usually the QI nurse that did this. Multiple attempts to contact NA #5 assigned to Resident #8 on 1/15/23 when the fall occurred were unsuccessful.	F 689	interviews with all alert and oriented residents regarding Smoking. This audit is to identify residents who smoke or desire to smoke to ensure all residents were educated on the smoke policy to include storage of smoke paraphernalia, designated smoke areas and were assessed by Director of Nursing for smoking safety with updated care plan as “supervised” or “safe/independent” smoker. Audit will be completed by 4/3/23. On 3/16/23, the Staff Development Coordinator initiated an in-service of all nurses regarding (1) Incident Reports with emphasis on reporting all incidents, investigating all incidents thoroughly to include obtaining statements and completion of investigative folder, assessment of the resident, initiating intervention based on root cause, notification of MD/RR and updating care plan for new interventions (2) Root Cause Analysis to include what is Root Cause Analysis, steps to determine root cause and presenting investigative findings to the team to review to review all possible actions that can prevent reoccurrence. In-services will be completed by 4/3/23. After 4/3/23, any nurse who has not worked or received the in-services will complete upon next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Incident Reports and Root Cause Analysis. On 2/21/23, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding	

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F 689	Continued From page 37 Resident #8's care guide indicated an intervention initiated on 1/16/23 to maintain access for staff to bed controller for resident care. On 1/24/23 the intervention of a mattress to floor at bedside for safety was initiated on Resident #8's care guide. MDS assessment on 1/26/23 indicated Resident #8 was discharged with return anticipated. MDS assessment on 1/30/23 indicated Resident #8 reentered the facility. A 1/30/23 reentry Falls Risk Evaluation indicated Resident #8 was a fall risk and follow up was required. The evaluation did not indicate what follow up was initiated. Observations during the survey revealed Resident #8 was in bed and the thick foam mattress was across the room leaned up against the closet on 2/19/23 at 12:52 PM, 2/20/23 at 1:11 PM, 2/20/23 at 4:25 PM, 2/21/23 at 8:36 AM, and 2/23/23 at 12:42 PM. Interview on 2/20/23 at 4:29 PM with Nursing Assistant (NA) #1 revealed he was assigned to Resident #8 regularly. NA #1 stated he did not know if Resident #8 had any falls and what fall precautions were in place. NA #1 indicated the care guide listed fall interventions for residents. Interview on 2/23/23 at 9:44 AM with Nurse #1 revealed that following a fall, staff on the floor sometimes initiated interventions for fall prevention but it was usually the Quality Improvement (QI) Nurses and the interdisciplinary team that discussed falls and put interventions in place.	F 689	Smoking Supervision/Monitoring Smoke Paraphernalia with emphasis on ensuring residents return all smoke paraphernalia following smoke sessions to be secured at nurses station, staff provide appropriate supervision to all residents identified as “supervised smoking” and that staff immediately report any resident in smoke area that is not properly supervised or any resident with smoke paraphernalia that is not secured per facility protocol. In-services will be completed by 4/3/23. After 4/3/23, any nurse or nursing assistant who has not worked or received the in-services will complete upon next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Smoking Supervision/Monitoring Smoke Paraphernalia The IDT Team includes Director of Nursing, Administrator, Administrative nurses, Quality Assurance (QA) nurse and Minimum Data Set (MDS) nurse will review all new incidents to include falls 5 times a week x 4 weeks utilizing the Incident Audit Tool. This audit is to ensure all incidents are investigated for root cause with appropriate intervention initiated based on root cause, resident assessed with documentation in electronic record, MD/RR notified, care plan/care guide updated and safety interventions in place per plan of care, statements obtained, and investigational summary completed. The Administrative nurses, QA nurse and MDS nurse will address all concerns identified during the audit to	

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F 689	Continued From page 38 Interview on 2/23/23 at 9:55 AM with MDS Coordinator #1 revealed she did not know why fall risk was not listed in Resident #8's 1/10/23 care plan when the Care Area Summary indicated falls were to be address. MDS Coordinator indicated the floor mat (mattress) should have been entered on Resident #8's care plan following the fall that occurred on 12/20/22 so that staff would be aware, and the falls focus should have been listed as well. Interview on 2/23/23 at 12:50 PM with Quality Improvement (QI) Nurse #1 revealed she completed an investigation of all falls. The investigation included obtaining witness statements and reviewing for recent changes but did not the identify root cause. QI Nurse #1 stated the investigation could take a while to complete. QI Nurse #1 stated she discussed each fall with the floor nurse and provided education to the resident regardless of their cognition. QI Nurse #1 stated she thought she might have talked to Resident #8 after one of the falls to remind her to use the call bell. QI Nurse #1 stated she determined interventions that needed to be implemented and added them to the care plan and care guide. QI Nurse #1 stated the floor mat was initiated for Resident #8 to prevent injury related to further falls, but she was not able to remember when. QI Nurse #1 did not know why it was not added to the care guide until 1/24/23 and was not aware of Resident #8 being able to move the floor mat (mattress). Interview on 2/23/23 at 2:34 PM with Director of Nursing (DON) revealed the floor nurse was to try to figure out the cause of the fall and initiate interventions immediately following the fall. DON	F 689	include but not limited to investigating incident, initiating appropriate interventions, notification of MD/RR, updating care plan and/or re-training of staff. The DON will review the Incident Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Activity Director, Medical Records Director and/or Accounts Receivable/Payable will complete 10 smoke observations weekly for 4 weeks, then monthly x 1 month utilizing the Smoking Supervision Audit Tool. This audit is to ensure residents return all smoke paraphernalia at the end of each smoke session to be secured at the nurse's station per facility protocol and that staff provide appropriate supervision for residents identified as "supervised smoking". The Activity Director, Medical Records Director and/or Accounts Receivable/Payable will address all concerns identified during the monitoring process to include re-education of staff/residents and providing supervision as applicable. The Administrator will review the Smoking Supervision Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The QA nurse will forward the Incident Audit Tool and the Smoking Supervision Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 month. The QAPI Committee will meet monthly x 2 month	

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F 689	Continued From page 39 stated QI Nurse #1 reviewed the falls, investigated them and was responsible for implementing new interventions including updating the care plan and care guide. DON stated the floor mat should have been added to the care plan and care guide following the fall that occurred on 12/20/22. DON stated the facility needed to improve the process of implementing interventions following a fall. Interview on 2/23/23 at 5:20 PM with the facility Medical Director revealed that after a resident sustained a fall, he expected the facility would review the fall, complete a new falls risk assessment, and evaluate factors that may have contributed to the fall including environment, medications, and medical conditions. The Medical Director revealed that it was imperative the facility had an awareness of what happened regarding the fall, followed the facility protocol, and implemented interventions to prevent future falls. In the case of a resident that sustained a fall with injury or harm it was particularly important to complete a root cause analysis of the fall and implement interventions as soon as possible to prevent further falls. 2). Resident #77 was admitted to the facility on 1/23/23 with diagnoses which included in part muscle weakness and blindness. 1/24/23 Admission Fall Risk Evaluation indicated Resident #77 was bedfast, had no behaviors, was independent and continent with severely impaired vision and was not a fall risk. Evaluation indicated follow up was required. The evaluation did not specify what follow up was initiated. Nursing progress note on 1/29/23 at 2:00 PM	F 689	and review the Incident Audit Tool and the Smoking Supervision Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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indicated Resident #77 was heard yelling and was observed on the floor at the doorway of his room lying on his right side propped up on the right forearm, head pointed at the doorway and feet pointed towards the wall. Resident sustained a scraped area that was bleeding on his left buttock and a long scratch on the left hip. Progress note indicated Resident #77's wife, who was a resident in the same room and is alert and oriented, stated Resident #77 was reaching over to pick up a paper when he fell.

Incident report completed on 1/29/23 at 1:52 PM by Nurse #9 revealed there were no witnesses to the incident. Incident report further indicated Resident #77 stated he went to the bathroom. There was no indication of interventions being implemented to address fall risk.

Resident #77's 1/30/23 admission Minimum Data Set (MDS) assessment indicated resident was cognitively intact, visually impaired and required extensive assistance with bed mobility and toileting, supervision with 1 person physical assist for transfers and ambulation, was frequently incontinent of bowel and bladder and had one fall since admission to the facility. The Care Area Assessment for falls was addressed with the decision to proceed to care plan.

Nursing progress note written by Nurse #2 on 2/6/23 revealed Resident #77 was found crawling on his hands and knees from the bathroom to his bed. No apparent injuries were noted. Resident #77 gave several stories regarding what happened including his legs gave out. Resident #77 was encouraged to use the call bell for assistance.

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Interview on 2/23/23 at 3:45 PM with Nurse #2 revealed Resident #77 was a high fall risk, was blind, did not use the call bell for assistance and had impaired safety awareness. Nurse #2 did not recall what safety interventions were implemented after Resident #77 fell. Nurse #2 stated she was assigned to Resident #77 on 2/6/23 when he was found on the floor. Nurse #2 stated she did not know how Resident #77 ended up on the floor, but he stated his legs gave out.

Resident #77's care plan revealed falls focus was added to the care plan on 2/20/23. Interventions included: call bell pinned to gown when in bed, observe and intervene for factors causing falls, keep call bell within reach and answer timely and fall prevention intervention (specify) with no interventions specified.

Interview on 2/23/23 at 9:49 AM with the MDS Coordinator #1 revealed the QI Nurse #1 completed the investigation regarding falls and implemented interventions. MDS Coordinator #1 stated falls should have been care planned for Resident #77 when the MDS was completed, and new interventions should have been entered after each fall. MDS Coordinator #1 indicated the interventions on the care plan transferred to the care guide which was used by the nursing assistants to determine each residents care. MDS Coordinator #1 acknowledged that high risk for falls, history of falls and fall interventions were not entered into Resident #77's care plan or care guide until 2/20/23.

Interview on 2/23/23 at 12:50 PM with QI Nurse #1 revealed she talked to Resident #77 about one of his falls and reminded him to use the call light to ask for assistance. QI Nurse #1 could not

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recall any other interventions that were implemented or if she completed a root cause analysis for Resident #77 for fall prevention.

Interview on 2/23/23 at 2:34 PM with Director of Nursing (DON) revealed the floor nurse implemented fall prevention interventions immediately following a fall. DON indicated QI Nurse #1 reviewed and investigated falls and implemented fall prevention interventions. QI Nurse #1 was responsible for making sure interventions were in place, updating the care plan or care guide and communicating the changes to staff.

Follow up interview on 2/23/23 at 4:30 PM with the DON revealed that following the fall Resident #77 sustained on 1/29/23, education was provided to the resident to remind him to use the call bell. DON was unable to locate the investigation that was completed or the interventions that were implemented following the fall that Resident #77 sustained on 2/6/23.

Interview on 2/23/23 at 5:20 PM with the facility Medical Director revealed that after a resident sustained a fall, he expected the facility would review the fall, complete a new falls risk assessment, and evaluate factors that may have contributed to the fall including environment, medications, and medical conditions. The Medical Director revealed that it was imperative the facility had an awareness of what happened regarding the fall, followed the facility protocol and implemented interventions to prevent future falls. In the case of a resident that sustained a fall with injury or harm it was particularly important to complete a root cause analysis of the fall and implement interventions as soon as possible to

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prevent further falls.

3. Resident #22 was admitted to the facility on 04/14/22 with medical diagnoses which included, intellectual disabilities, and tobacco use

Resident's 01/12/23 care plan revealed resident acted in a problematic way by inappropriate smoking related to decreased safety awareness. Resident's smoking interventions included: Nursing staff to assist resident to the designated smoking area during established/predetermined facility smoking times, not to leave resident unattended while smoking, supervise resident while smoking, document episodes of inappropriate smoking or potential smoking policy violations and report observations to Administrator and/or administrative staff, place smoking materials at nurses' station for storage, provide resident education on smoking policy, and provide a smoking apron for resident.

Resident's 01/27/23 quarterly Minimum Data Set (MDS) assessment revealed resident had no cognitive impairments, was assessed as independent with locomotion on and off the unit, and he utilized a wheelchair.

A nursing behavior note dated 02/17/23 at 2:49 PM for Resident #22 revealed resident went outside to smoke without supervision. Nurse did not provide resident with a cigarette and nurse did not know from whom resident obtained a cigarette. Resident was reminded of the importance of having staff supervision for continued smoking privilege.

Resident's 02/19/23 smoking evaluation revealed resident was an unsafe smoker and required

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direct supervision while smoking. Resident was re-educated on the smoking policy and was given a copy of the policy.

Observation on 02/20/23 at 9:40 AM revealed Resident #22 sitting outside in his wheelchair next to the exit door to the smoking area, lighting up, and smoking a cigarette without staff supervision in the smoking area or with the resident. Resident was without a smoking apron, was not in the designated smoking area, and was smoking within one foot from the exit door.

Multiple interviews were attempted with Resident #22, but he declined to be interviewed.

Interview on 02/20/23 at 9:45 AM with Quality Initiative (QI) nurse revealed she had no idea how Resident #22 got his cigarette. QI nurse also observed there was no sitter with him.

Interview on 02/20/23 at 9:50 AM with the Director of Nursing (DON) revealed Resident #22 knew about the facility's smoking policy and was re-educated many times on it. He said the resident smoked outside without supervision before. DON said the resident should have been supervised by staff, should have had a smoking apron on, should have waited for staff to provide him with a cigarette and lighter, and should have smoked in the designated smoking area and not right next to the exit door.

A Director of Nursing (DON) note dated 02/20/23 at 10:56 AM revealed she became aware that Resident #22 was outside in the smoking area smoking. Resident was a supervised smoker. Resident's nurse assisted resident to his room and asked the resident where he obtained a

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cigarette. Resident stated the cigarette came from his drawer in his room but would not disclose who he got the cigarette from. Resident also gave a lighter to the nurse to be locked up on the medication cart. Resident was re-educated on the smoking policy.

Nursing note by DON dated 02/20/23 at 1:05 PM for Resident #22 revealed it was reported to his nurse that resident was outside smoking without supervision. Resident had been re-educated numerous times that he was not to go outside and smoke alone. Resident refused to comply with the smoking policy. Resident became upset when told that he must wait for someone to supervise him to go smoke. Resident began to use foul language and stated that he's a grown man and had the right to do what he wanted to do. Resident continued to state that other people go out to smoke when they want to, and he could too. Nurse reminded resident that he was not a safe smoker, and per facility policy, he had to be always supervised when smoking. Per DON, resident was to be on every 15-minute checks, to ensure resident was not going out to smoke without supervision and for resident's safety. Resident verbalized understanding that he was to wait for someone to take him out to smoke and that he was not to get cigarette butts off the ground nor was he to get cigarettes from other residents. Resident was also educated that his cigarette lighter was to be kept by the nurse or the staff taking him out to smoke at-all-times. Resident was aware that he was not to have a cigarette lighter on his person at any time.

Interview on 02/21/23 at 8:25 AM with the Administrator revealed Resident #22's was one of their three supervised smokers and should have

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been supervised in the designated smoking area with a smoking apron on. She said the resident's smoking materials were expected to be housed and locked in the nurse's medication cart and would only be accessible with the aid of a staff member. She stated smoking was only allowed in the designated area and not outside next to the exit door to the smoking area.

4. Review of the facility smoking policy read in part, "Smoking materials for safe smokers will be required to be locked in the nurse's medication cart. When a resident wants to smoke, they must request the staff for a maximum of 2 cigarettes at a time and a lighter. After the resident is finished smoking, they must turn the lighter and any unsmoked cigarettes back in to the staff to be locked back in the medication cart."

Resident #127 was admitted to the facility on 10/04/2022 with diagnoses to include rheumatoid arthritis and muscle weakness.
Review of the admission Minimum Data Set (MDS) assessment dated 10/10/2022 revealed Resident #127 was cognitively intact and tobacco use was coded as no.

Review of Resident #127's electronic medical record (EMR) revealed a nurse's note that read in part, "Resident continues to smoke."
Resident #127 was observed sitting in the smoking area smoking a cigarette on 02/19/2023 at 12:47 P.M.

Review of the (EMR) revealed a smoking assessment was completed for Resident #127 on 02/19/2023 at 02:13 P.M. and she was coded as a safe and independent smoker.

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Review of Resident #127's care plan updated 02/19/2023 revealed a plan of care for safe and independent smoker with interventions to include: to provide resident education on smoking policy and assist resident in obtaining smoking materials from secured storage area upon request.

An observation and interview with Resident #127 were conducted on 02/21/23 at 01:25 P.M. Resident #127 was sitting in the smoking area smoking a cigarette. Resident #127 stated that she had been smoking since she was admitted to the facility. She further stated that she kept her cigarettes and lighter in her purse. Resident #127 indicated the facility had never asked her to give them her cigarettes and lighter for safe storage. Resident #127 stated that she was going to give her lighter and cigarettes to the nurse today for safe storage. She further stated that her Responsible Party (RP) brought her cigarettes to her at the facility.
An interview with Certified Medication Aide (CMA) #1 was conducted on 02/22/2023 at 11:00 A.M. CMA #1 stated that Resident #127's cigarettes and lighter were now locked in the medication cart. She further stated they didn't usually lock up the residents' smoking materials on this unit because they were all safe and independent smokers.

An interview was completed with Nurse #9 on 02/22/2023 at 11:05 A.M. Nurse #9 stated that she had only worked at the facility for a few weeks and was still learning the residents. She further stated that she was aware that Resident #127 was a smoker. Nurse #9 further stated that Resident # 127's lighter and cigarettes were locked in the medication cart now.

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An interview was conducted with Unit Manager #1 on 02/22/2023 at 11:10 A.M. Unit Manager #1 stated that newly admitted residents should have a smoking assessment completed upon admission to the facility. Unit Manager #1 explained that Resident #127 was admitted on another unit in the facility, and it must have been missed on admission. She indicated that any nurse could conduct a smoking assessment and it should have been completed before 02/19/2023. Unit Manager #1 stated that all of the residents' smoking materials should be locked in the medication cart even the ones that were assessed to be safe and independent smokers.

An interview was completed with Administrator #2 on 02/23/2023 at 11:20 A.M. Administrator #2 stated that she was the "fill-in" Administrator, because the facility Administrator was on vacation. She further stated that she was not familiar with Resident #127, but when a resident was identified as a smoker the smoking assessment should be completed. Administrator #2 indicated smoking assessments were very important in determining whether residents needed to be supervised in order to prevent accidents from occurring. Administrator #2 indicated that residents who smoked were supposed to turn their cigarettes and lighter into the facility staff when they finished smoking for safety reasons.

An interview with the Director of Nursing (DON) occurred on 02/23/2023 at 11:55 A.M. The DON stated that a smoking assessment should have been completed for Resident #127 when she was admitted or as soon as she was identified as a smoker. He further stated that he did not know

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why the smoking assessment had not been completed prior to 02/19/2023. The DON indicated that the facility staff should have locked up Resident #127's smoking materials when she was identified as a smoker.
5) Resident #104 was admitted to the facility on 11/22/22. Diagnoses included tobacco use.

A smoking agreement was signed upon admission on 11/22/22 by Resident #104. The smoking agreement read, in part, "a resident deemed as a safe unsupervised smoker will be permitted to smoke in the designated smoking area at a time of their choosing. Smoking materials for a safe smoker will still be required to be locked in the nurse's medication cart. When a resident wants to smoke, they may request for a maximum of 2 cigarettes at a time and a lighter. After the resident was finished with smoking, they must turn the lighter and any unsmoked cigarettes back to the staff to be secured in the medication cart."

The Minimum Data Set 5 day admission assessment dated 11/28/22 revealed Resident #104 was cognitively intact. He was independent with set up only with all activities of daily living and was coded as a current tobacco user.

A review of Resident #104's care plan dated 11/28/22 revealed Resident #104 was an independent and safe smoker of tobacco. Interventions included to assist resident in obtaining smoking materials from secured storage area upon request, observe for potential violations of the smoking policy and document and report observations to the Administrator or Administrative staff, provide education on smoking policy, and upon return from smoking

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ensure smoking materials were returned and secured in the storage area.

A smoking assessment was completed on 12/22/22 and 01/23/23. Resident #104 was determined to be a safe and independent smoker.

An observation of the medication storage cart with Nurse #5 on 02/22/23 at 11:23 AM revealed cigarettes with residents' names were stored on the bottom draw of the medication storage cart. There were no cigarettes for Resident #104 in the drawer.

An interview was conducted with Nurse #5 on 02/22/23 at 11:23 AM. Nurse #5 revealed Resident #104 was an independent and safe smoker and would go outside frequently to smoke. During the interview, Resident #104 was noted to be in his room. Nurse #5 had shown where the cigarettes were stored and described which residents' the cigarettes belonged too. Nurse #5 stated Resident #104 kept his cigarettes and lighter on him and would return them at the end of the shift. Nurse #5 stated she was not aware of the policy that independent smokers needed to return their cigarettes and lighter when they were done with their smoke break.

An observation of Resident #104 on 02/22/23 at 3:15 PM revealed he had a pack of cigarettes and a lighter sticking out of his pants pocket.

During an interview with Resident #104 on 02/22/23 at 3:15 PM he reported he did not return his cigarettes and lighter to the nurse when he was done smoking outside. He stated he kept

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F 689	Continued From page 51 them on his person. Resident #104 added, he had rights, and he was not a prisoner. Resident #104 stated he probably signed the smoking agreement when he was admitted but he did not remember. Resident #104 stated he was aware of the facility's policy, but he was going to continue to carry his own cigarettes and lighter on him. An interview with the Director of Nursing (DON) on 02/22/23 at 4:10 PM revealed Resident #104 should be adhering to the smoking policy and if he was not going to return his cigarettes and lighter, he would be addressed about a 30 day discharge. The DON added, Resident #104 was aware of the policy and signed the smoking policy agreement upon admission. The DON stated Resident #104 needed to adhere to the policy for his safety and the safety of other residents.	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		4/3/23

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F 756	Continued From page 52 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Nurse Practitioner, Pharmacist Consultant, and staff interviews the facility failed to implement a pharmacy recommendation which resulted in a resident (Resident #55) not receiving her daily dose of Victoza (a non-insulin medication to treat diabetes) for 21 days for 1 of 5 residents reviewed for unnecessary medications. Findings included: Resident #55 was admitted to the facility on 08/26/21. Diagnoses included, in part, insulin dependent diabetes mellitus. The Minimum Data Set annual assessment dated	F 756	F 756 Drug Regime Review, Report Irregular, Act on On 2/22/23, the physician was notified that Victoza was not provided as ordered for resident #55. The order for Victoza was clarified with a new order obtained for Victoza 1.2mg daily. Order was initiated on 2/23/23. The resident was assessed with no adverse effects noted. On 3/16/23, the Director of Nursing initiated an audit of all pharmacy recommendations from 11/1/22 to 3/14/23. This audit was to ensure all recommendations were reviewed by the	

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F 756	Continued From page 53 12/21/22 revealed the resident was cognitively intact and received 7 days of insulin during this assessment. Review of the physician orders revealed orders written on 12/19/22 to include Glargine Solution (long acting basal insulin) Pen Injector 100 units/milliliter (ml), inject 45 units subcutaneously every 12 hours and Humalog (short acting insulin) KwickPen Solution Pen Injector 100 units/ml, inject per sliding scale subcutaneously three times daily for diabetes mellitus. A care plan review updated on 12/21/22 revealed a plan of care for diabetes mellitus with potential for complications related to hyperglycemia (high blood sugar level) and hypoglycemia (low blood sugar level). Interventions included, in part, administer medication as ordered by the physician, monitor for signs and symptoms of hyper and hypoglycemia, discuss mealtimes, portion sizes, dietary restrictions, snacks allowed within dietary rotation and importance of benefits of compliance with nutritional regimen with resident. A Physician's order written on 12/24/22 revealed Trulicity Solution (a weekly injectable to improve blood sugars) Pen Injector 3 milligrams (mg)/0.5(ml), inject 3 mg subcutaneously one time a day every Saturday for diabetes mellitus. Review of a Drug Therapy Management Recommendation from the facility's pharmacy dated 01/17/23 for Resident # 55 revealed, in part, "this resident received Trulicity 3 milligrams mg/0.5 ml. There is currently a nationwide shortage of Trulicity strengths of 3mg/0.5ml and 4.5 mg/0.5ml. Please consider changing Trulicity	F 756	physician and new orders transcribed accurately and timely to the medication administration record (MAR) and administered per physician orders. The Director of Nursing (DON) addressed all concerns identified during the audit to include but not limited to assessment of the resident, notification of the physician for further recommendations and/or clarification of orders and initiating new orders when indicated. Audit will be completed by 4/3/23. On 2/23/23, the Director of Nursing (DON) initiated an in-service with all nurses regarding Pharmacy Recommendations with emphasis on ensuring recommendations are reviewed by the physician timely and all new orders transcribed accurately utilizing a two-nurse check system and administered per physician orders. In-services will be completed by 4/3/23. After 4/3/23/23, any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will receive this in-service during orientation. The Minimum Data Set Nurses (MDS) will audit pharmacy recommendations monthly x 2 months to ensure recommendations are reviewed by the provider timely and all newly written orders are transcribed to the medication administration record accurately utilizing a two-nurse check system and administered per physician orders. The MDS nurse will address all concerns identified during the	

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F 756	Continued From page 54 to Victoza subcutaneously daily. Discontinue Trulicity and one week later on the same day of the week, start Victoza 0.6 mg subcutaneously once daily for 1 week, then 1.2 mg subcutaneously once daily. The 0.6 mg dose is a starting dose intended to reduce gastrointestinal symptoms during initial titration and is not effective for glycemic control. This recommendation was agreed to and signed by Nurse Practitioner (NP) #1 on 01/23/23. A physician order written on 01/24/23 revealed Trulicity 3mg/0.5ml was discontinued. A physician's order written on 01/28/23 revealed Victoza subcutaneous Solution Pen Injector 18 mg/3ml, inject 0.6 mg subcutaneous one time a day every Saturday for diabetes mellitus. These orders were noted to be entered by Unit Manager #1. There was no actual physician order noted for Victoza subcutaneous Solution Pen Injector 18 mg/3ml, inject 1.2 mg daily. Review of the Medication Administration Record (MAR) for January 2023 revealed Victoza 18mg/3ml, inject 0.6 subcutaneous one time a day every Saturday related to diabetes with a start date of 01/28/23 and an end date of 02/04/23. The MAR indicated Resident #55 received a dose of 0.6 mg on Saturday, 01/28/23 and on Saturday, 02/04/23. Resident #55 did not receive the 0.6 mg dose daily for one week as ordered and missed 6 doses. Additionally, the MAR revealed Victoza 1.2 mg subcutaneous one time a day every Saturday starting 02/11/23. The MAR indicated Resident #55 received a dose of 1.2 mg on Saturday, 02/11/23 and Saturday, 02/18/23. Resident #55 did not receive the 1.2 mg dose daily as ordered and missed 15 doses.	F 756	audit to include assessment of resident and initiating orders when indicated and/or notification of the physician for further recommendations. The Director of Nursing (DON) will review the audit of pharmacy recommendations monthly x 3 months to ensure all concerns are addressed. The DON will present the findings of the Pharmacy Recommendation Audit to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Pharmacy Recommendation Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 756	Continued From page 55	F 756		

Resident #55's blood sugar results were reviewed from December 1, 2022, through February 22, 2023. The blood sugar results were at baseline with elevated results varying. Blood sugar results did not change as a result of Resident #55 missing 21 doses of the Liraglutide. Record review also revealed Resident #55 was non-compliant with her diet and was encouraged to eat sugar free desserts.

An observation of Resident #55 on 02/19/23 at 11:45 AM revealed an alert and oriented resident sitting upright in her wheelchair eating chocolate chip cookies. There were noted to be packages of cookies on her nightstand.

An interview with Nurse #8 on 02/20/23 at 10:20 AM revealed Resident #55 was on the sliding scale and her blood sugars were checked 3 times a day. Nurse #8 stated she has had no signs or symptoms of hyperglycemia or hypoglycemia.

An interview was conducted with Unit Manager (UM) #1 on 02/21/23 at 2:45 PM. The Unit Manager stated after she received the signed Drug Therapy Management Recommendation from the Nurse Practitioner, she saw the Nurse Practitioner in the hall and asked her about the Victoza order and questioned if it should be administered every Saturday as the Trulicity was. The UM stated the NP instructed her to put the order in weekly like the Trulicity order. UM #1 stated she did not know if any other nurse reviewed the order after she put it into the computer system.

An interview was conducted with Nurse Practitioner (NP) #1 on 02/22/23 at 9:40 AM. The NP stated Victoza was used to help treat diabetes

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F 756	Continued From page 56	F 756		

and it was given daily. She stated she recalled the Drug Therapy Management Recommendation that was sent from the Pharmacy regarding the nationwide shortage of the Trulicity. She stated she reviewed the recommendation, agreed to the recommendation, and signed it. Once she signed it was given to the nurses to put the order in computer system. The NP added, she recalled having to look up the drug to see clarify the recommendations because she was not familiar with the drug. NP #1 stated Victoza was intended to be administered daily, not weekly. She stated she recalled having a discussion at the nurse's station regarding the nationwide shortage, but she did not instruct UM #1 to give the medication weekly on Saturdays like the Trulicity order was. NP #1 stated Resident #55 has had elevated blood sugars prior to the Trulicity order and continued to have them periodically, and added, she felt as though it was more diet related as opposed to not receiving the Victoza as ordered, but that the Victoza would help to keep the blood sugars stable. The NP stated once she signed the recommendation, she would have expected the nursing staff to fax it to the pharmacy and implement the orders as written.

An interview was conducted with the Pharmacist Consultant on 02/22/23 at 11:15 AM. The Pharmacist Consultant stated the Drug Therapy Management Recommendation came directly from the pharmacy due to the shortage of the Trulicity. She stated the Victoza recommendation had the correct dosing and should have been administered daily. The Pharmacist Consultant added, it was a medication error that the order was implemented for once a week instead of daily. She stated in this particular case since Resident #55 was on a sliding scale with a short

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F 756	Continued From page 57	F 756		

acting insulin 3 times a day for any elevated glucose levels, they (the blood sugars) would have also been treated because of her basal (long acting) insulin. She stated she did not feel it was harmful to the resident that she did not receive 21 doses of the Victoza and stated the resident's glucose may have been slightly better. She stated the long acting basal insulin and the fast acting insulin were the better medications for reducing blood sugar which she had been receiving. The Pharmacist Consultant stated the Victoza provided additional support and acted as an agonist and adjunct that was supposed to make the body's response to insulin improve. She stated it would not cause a huge increase in blood sugars even with residents who were not compliant with their diet.

An interview was conducted with the Director of Nursing (DON) on 02/22/23 at 4:13 PM. He stated whenever a Drug Therapy Medication Recommendation was sent directly from the Pharmacy and was signed by the Physician or Nurse Practioner, it would become an order. He stated the signed recommendation would be given to the Unit Managers to put into the computer system and implement the order. He stated he was not sure how it was transcribed incorrectly because since July of 2022 he had implemented that three nurses should be confirming the orders to make sure the medication was transcribed to include right patient, right dose, right frequency, right route, and the right time to verify orders were entered correctly. The DON added, this was a medication error and further education needed to be provided to the Unit Managers and nursing staff to prevent this from reoccurring.

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F 758	Continued From page 58	F 758		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		4/3/23

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F 758	Continued From page 59 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner and Consultant Pharmacist interviews, the facility failed to accurately transcribe and administer a medication used to treat depression resulting in 23 doses administered at a higher dose than ordered for 1 of 3 residents (Resident #8) reviewed for psychotropic medication (a medication used to treat behavior, mood, thoughts, or perception). Findings included: Resident #8 was readmitted to the facility on 1/30/23 with diagnoses which included in part dementia with behaviors, depression, and anxiety. The 1/30/23 discharge summary medication list for Resident #8 included an order for sertraline 50 milligrams (mg.) give 25 mg daily. A physician order dated 1/30/23 was entered by Quality Improvement (QI) Nurse #2 for sertraline 50 milligrams (mg.) give 1 tablet by mouth one time a day for depression	F 758	F 758 Free of Unnecessary Psychotropic Meds/PRN use Resident #8 no longer resides in the facility. On 3/16/23, the Director of Nursing and facility consultant initiated an audit of all current residents admitted between 1/1/23 and 3/14/23 discharge medications, to include but not limited to psychotropic medications. All current residents' discharge summaries were compared to facility medication orders to ensure medications were transcribed accurately to the medication administration record (MAR) upon admission and administered per physician orders. The Director of Nursing (DON), and/or Administrative nurses will address all concerns identified during the audit to include but not limited to assessment of the resident, initiating orders per physician recommendation and/or notification of the physician for further recommendations for any concerns identified. The audit will be	

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F 758	Continued From page 60 Admission Drug Regimen Review on 1/31/23 indicated the order for sertraline required clarification and noted the order on the discharge summary read sertraline 50 mg. with the direction to give 25 mg daily. Order in the computer reads 50 mg daily. Please clarify. A handwritten notation on the Drug Regimen Review stated "hospital d/c order is 25 mg. give 50 mg. order in computer for 50 mg. to lessen pills. Initials of Unit Manager #1 and date of 2/1/23 were written on the bottom of page. Review of the Medication Administration Record (MAR) for January 2023 revealed sertraline 50 mg. once per day start date of 1/31/23 at 8:00 AM. The MAR indicated Resident #8 received sertraline 50 mg. once per day on 1/31/23. February 2023 MAR revealed sertraline 50 mg. once per day with start date of 1/31/23 and end date of 2/22/23. MAR indicated sertraline 50 mg. was received daily from 2/1/23 through 2/22/23. Nurse Practitioner progress note on 2/22/23 indicated the nurse reported a medication error since Resident #8 was readmitted on 1/30/23 in which the discharge summary medication list indicated sertraline 25 mg. daily. Order was transcribed as sertraline 50 mg. daily and Resident #8 received 50 mg. sertraline daily since 1/31/23. NP indicated to change dose of sertraline to 25 mg. daily. Interview on 2/22/23 at 10:00 AM with the Nurse Practitioner (NP) revealed when a resident was admitted or readmitted to the facility the nurses entered the medications from the discharge summary into the electronic health record. NP stated that she was not given a copy of the orders to review or verify when a resident was admitted	F 758	completed by 4/3/23. On 2/23/23, the administrator initiated an in-service with the Director of Nursing, Quality Assurance Nurse, Nurse Supervisor, Staff Development Coordinator and Nurse Facilitator on the Process for Completion of the Admission Checklist to include medication reconciliation for new admissions, validating orders were transcribed accurately to the medication administration record and/or notify the physician of any discrepancies for further recommendations. The Director of Nursing, Quality Assurance Nurse, Nurse Supervisor, Staff Development Coordinator and Nurse Facilitator will review all new admissions utilizing the admission check list during the next scheduled clinical meeting held Monday through Friday to ensure the admission process was completed. This in-service will be completed by 4/3/23. All newly hired Directors of Nursing, Quality Assurance Nurses, Nurse Supervisors, Staff Development Coordinators and Nurse Facilitators will receive this in-service during orientation regarding the Process for Completion of the Admission Checklist. On 2/23/23, the Director of Nursing (DON) initiated an in-service with all nurses regarding (1) Transcribing Physician Orders with emphasis on utilizing a 2 nurse verification system for all new orders to include but not limited to admission/readmission orders, and a final	

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F 758	Continued From page 61 or readmitted. NP stated she sometimes received a copy of the discharge summary at some point but not immediately upon the resident entering the facility. NP stated she did not verify the orders for Resident #8. NP stated she evaluated residents within 72 hours of admission or readmission to the facility. NP revealed the pharmacy drug reviews on admission or readmission were not given to her to review regularly. Sometimes she was provided with the pharmacy drug regimen review but not always. NP stated she was not provided with the 1/31/23 Admission Drug Regimen Review for Resident #8 and was not asked to clarify the sertraline dose. NP indicated an increase in dose of the medication sertraline can have side effects including lethargy and decreased activity, intake, and appetite. Interview on 2/22/23 at 11:15 AM with the Consultant Pharmacist indicated the pharmacy used the discharge summary to compare the orders to determine if they have been entered into the computer correctly. When the pharmacy observed a discrepancy in an order, such as sertraline 50 mg. entered and the discharge summary indicated the order was for 25 mg, they alerted the facility for clarification via the Admission Medication Regimen Review form. Administration of a higher dose of sertraline than ordered was a medication error and could result in side effects including increased sleepiness, nausea, diarrhea, and dizziness. Interview on 2/22/23 at 3:33 PM with Unit Manager #1 revealed she made the mistake with the sertraline order. Unit Manager #1 stated she looked at the order wrong when she indicated on the pharmacy admission medication regimen	F 758	verification of order entry completed by the Administrative Nurse utilizing the Admission Checklist and (2) Pharmacy Recommendations with emphasis on ensuring recommendations are reviewed by the physician timely and all new orders transcribed accurately utilizing a two-nurse check system and administered per physician orders. In-services will be completed by 4/3/23. After 4/3/23, any nurse who has not worked or received the in-services will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation regarding Transcribing Physician Orders and Pharmacy recommendations. The Administrative team to include Quality Assurance (QA) nurse, Nurse Supervisor, Minimum Data Set (MDS) nurse, Staff Facilitator and Nurse Facilitator will review the Day of Admission Checklist/Orders Listing Report compared to resident Discharge Summary 5 times a week x 4 weeks then monthly x 1 month. This audit is to ensure the facility follows the admission process to include review of the discharge summary, verifying admission orders with the physician to include but not limited to psychotropic medications, ensuring medications are transcribed accurately to the MAR/TAR utilizing a two-nurse check system, and that medications are administered per physician orders. The QA nurse, Nurse Supervisor, MDS nurse, Staff Facilitator and Nurse Facilitator will address all concerns identified during the audit to	

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F 758	Continued From page 62 review that the sertraline did not need to be clarified. Unit Manager #1 stated she did not inform the provider that the sertraline dose required clarification. Unit Manager #1 stated when she received the Admission Medication Regimen Review, she typically changed the orders if they required clarification and did not show them to the provider. Interview on 2/22/23 at 4:00 PM with the Director of Nursing (DON) revealed that the orders for a new admission or readmission to the facility were taken from the discharge summary. Admissions received the discharge summary from the hospital. The discharge summary was given to Unit Manager #1 to enter the orders into the computer and contact the provider to verify the orders. DON stated sometimes the nurse notified and verified the orders with the provider right away but not always. DON stated he expected the provider to be notified and the orders verified within 24 hours. DON stated he was not sure how the order was transcribed incorrectly because since July 2022 he had implemented a system that required three nurses to confirm the orders to make sure the medication was transcribed to include right patient, right medication, right dose, right frequency, right route, and the right time to ensure all orders were transcribed correctly. DON stated he was not aware that there had been a medication error made with Resident #8's medication.	F 758	include but not limited to completion of the Admission Checklist, transcribing medications and administering medications per physician orders, assessment of the resident when indicated and notification of the physician for any discrepancies for further recommendations. The DON will review the Admission Checklist/Orders listing report/Discharge Summary Audit 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Minimum Data Set Nurses (MDS) will audit pharmacy recommendations monthly x 2 months to ensure recommendations are reviewed by the provider timely and all newly written orders are transcribed to the medication administration record accurately utilizing a two-nurse check system and administered per physician orders. The MDS nurse will address all concerns identified during the audit to include assessment of resident and initiating orders when indicated and/or notification of the physician for further recommendations. The Director of Nursing (DON) will review the audit of pharmacy recommendations monthly x 3 months to ensure all concerns were addressed. The DON will present the findings of the Pharmacy Recommendation Audit and the Day of Admission Checklist/Orders listing report/Discharge Summary Audit to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will	

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F 758	Continued From page 63	F 758	meet monthly for 2 months and review the Pharmacy Recommendation Audit and the Day of Admission Checklist/Orders listing report/Discharge Summary Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner and Consultant Pharmacist interviews, the facility failed to accurately transcribe and administer a medication used to treat hypertension (high blood pressure) resulting in 8 doses administered in error for 1 of 1 residents (Resident #8) reviewed for medication error. Findings included: Resident #8 was admitted to the facility on 11/23/22 with diagnoses which included in part hypertension (high blood pressure), atrial fibrillation, congestive heart failure and coronary artery disease. Discharge Summary 11/23/22 indicated Resident #8 was to receive metoprolol succinate (a long acting medication to treat high blood pressure)100 milligrams (mg) every morning. A physician order dated 11/23/22 was entered by	F 760	F 760 Residents are Free of Significant Med Errors Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the	4/3/23

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F 760	Continued From page 64 Unit Manager #1 for metoprolol tartrate (a short acting form of the medication used to treat high blood pressure) 100 mg. for hypertension. Pharmacy Admission Drug Regimen Review for Resident #8 on 11/25/22 revealed no hospital discharge summary was received in the pharmacy. Review of the Medication Administration Record (MAR) for November 2022 for Resident #8 revealed metoprolol tartrate 100 mg. in the morning for hypertension start date of 11/24/22 at 8:00 AM and end date of 12/1/22 at 11:31 AM. The MAR indicated Resident #8 received metoprolol tartrate 100 mg. once per day on 11/24/22, 11/25/22, 11/26/22, 11/27/22, 11/28/22, 11/29/22 and 11/30/22. December 2022 MAR revealed metoprolol tartrate 100 mg. once per day was received on 12/1/22. Nurse Practitioner (NP) progress note on 12/1/22 indicated Resident #8 was seen and evaluated regarding atrial fibrillation due to staff noted resident was not acting like herself and had an increased heart rate. NP progress note further indicated the NP reviewed the facility medication administration record and noted Resident #8 was receiving metoprolol tartrate 100 milligrams daily, but the discharge summary indicated Resident #8 was ordered metoprolol succinate 100 milligrams daily upon discharge. NP indicated that nursing was advised to review more closely, and order medications as prescribed by the physician. A physician order dated 12/1/23 was entered by Unit Manager #1 on 12/1/22 for metoprolol succinate extended release 100 mg. once per day. Metoprolol tartrate 100 mg. once per day	F 760	deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident #8 no longer resides in the facility. On 3/16/23, the Director of Nursing and facility consultant initiated an audit of all current residents admitted between 1/1/23 and 3/14/23 discharge medications, to include but not limited to hypertensive medications. All current residents' discharge summaries were compared to facility medication orders to ensure medications were transcribed accurately to the medication administration record (MAR) upon admission and administered per physician orders. The Director of Nursing (DON), and/or Administrative nurses will address all concerns identified during the audit to include but not limited to assessment of the resident, initiating orders per physician recommendation and/or notification of the physician for further recommendations for any concerns identified. The audit will be completed by 4/3/23. On 2/22/23, the administrator initiated an in-service with the Director of Nursing, Quality Assurance Nurse, Nurse Supervisor, Staff Development Coordinator and Nurse Facilitator on the Process for Completion of the Admission Checklist to include medication reconciliation for new admissions,	

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F 760	Continued From page 65 was discontinued on 12/1/22. Interview on 2/21/23 at 2:43 PM with Unit Manager #1 revealed she was in the position since October 2022. Unit Manager #1 stated that she entered the orders for a new admission or readmission from the Discharge Summary. Unit Manager #1 stated she did not have a provider review or verify the medications listed on the Discharge Summary prior to entering them in the computer. Unit Manager Alex stated she did not recall why she entered metoprolol tartrate instead of metoprolol succinate as listed on the discharge summary for Resident #8 when resident was admitted on 11/23/22. Interview on 2/22/23 at 10:00 AM with the Nurse Practitioner (NP) revealed when a resident was admitted or readmitted to the facility the nurses entered the medications from the discharge summary into the electronic health record. NP stated that she was not given a copy of the orders to review or verify when a resident was admitted or readmitted. NP stated she sometimes received a copy of the discharge summary at some point but not immediately upon the resident entering the facility. NP stated she did not verify the orders for Resident #8. NP stated she evaluated residents within 72 hours of admission or readmission to the facility. NP stated that there is a difference between metoprolol tartrate and metoprolol succinate. Metoprolol tartrate is an immediate acting medication whereas metoprolol succinate is a long acting or extended release and giving the incorrect form could result in changes in blood pressure and pulse. NP stated nurses needed to be careful when transcribing orders for medications that have more than one preparation and that can act	F 760	validating orders were transcribed accurately utilizing a two-nurse check system to the medication administration record and/or notify the physician of any discrepancies for further recommendations. The Director of Nursing, Quality Assurance Nurse, Nurse Supervisor, Staff Development Coordinator and Nurse Facilitator will review all new admissions utilizing the admission check list during the next scheduled clinical meeting held Monday through Friday to ensure the admission process was completed. This in-service will be completed by 4/3/23. All newly hired Directors of Nursing, Quality Assurance Nurses, Nurse Supervisors, Staff Development Coordinators and Nurse Facilitators will receive the in-service during orientation regarding the Process for Completion of the Admission Checklist. On 2/23/23, the Director of Nursing (DON) initiated an in-service with all nurses regarding (1) Transcribing Physician Orders with emphasis on utilizing a 2-nurse verification system for all new orders to include but not limited to admission/readmission orders, and a final verification of order entry completed by the Administrative Nurse utilizing the Admission Checklist. In-service will be completed by 4/3/23. After 4/3/23, any nurse who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired nurses will receive the in-service by the Staff Facilitator during orientation	

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F 760	Continued From page 66 differently. Interview on 2/22/23 at 10:58 AM with Consultant Pharmacist revealed there was a difference between metoprolol tartrate and succinate. Tartrate is a short acting preparation of the medication whereas succinate is a long acting or extended release form of the medication. Consultant Pharmacist stated the two medications are not interchangeable and that giving the wrong form of the medication constituted a medication error. Consultant Pharmacist stated that giving the short acting medication instead of the extended release could release in elevated blood pressures later in the day. Consultant Pharmacist stated the pharmacy completed admission drug regimen reviews and compared the medications that were entered into the electronic system with the discharge summary, however if they did not receive the discharge summary, as in the case of Resident #8, the review would be incomplete. Consultant Pharmacist stated that the admission drug review that was completed on 11/25/22 indicated the pharmacy did not receive the discharge summary. Interview on 2/22/23 at 4:00 PM with the Director of Nursing (DON) revealed that the orders for a new admission or readmission to the facility were taken from the discharge summary. Admissions received the discharge summary from the hospital. The discharge summary was given to Unit Manager #1 to enter the orders into the computer and contact the provider to verify the orders. DON stated sometimes the nurse notified and verified the orders with the provider right away but not always. DON stated he expected the provider to be notified and the orders verified	F 760	regarding Transcribing Physician Orders. The Administrative team to include Quality Assurance (QA) nurse, Nurse Supervisor, Minimum Data Set (MDS) nurse, Staff Facilitator and Nurse Facilitator will review the Admission Checklist/Orders Listing Report compared to resident Discharge Summary 5 times a week x 4 weeks then monthly x 1 month. This audit is to ensure the facility follows the admission process to include review of the discharge summary, verifying admission orders with the physician to include but not limited to psychotropic medications, ensuring medications are transcribed accurately to the MAR/TAR utilizing a two-nurse check system, and that medications are administered per physician orders. The QA nurse, Nurse Supervisor, MDS nurse, Staff Facilitator and Nurse Facilitator will address all concerns identified during the audit to include but not limited to completion of the Admission Checklist, transcribing medications and administering medications per physician orders, assessment of the resident when indicated and notification of the physician for any discrepancies for further recommendations. The DON will review the Admission Checklist/Orders listing report/Discharge Summary Audit tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Admission Checklist/Orders listing report/Discharge Summary Audit to the	

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F 760	Continued From page 67 within 24 hours. DON stated he was not sure how the order was transcribed incorrectly because since July 2022 he had implemented a system that required three nurses to confirm the orders to make sure the medication was transcribed to include right patient, right medication, right dose, right frequency, right route, and the right time to ensure all orders were transcribed correctly. DON stated he was not aware that there had been a medication error made with Resident #8's metoprolol.	F 760	Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Admission Checklist/Orders listing report/Discharge Summary Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		4/3/23

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F 761	Continued From page 68 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and review of the manufacturers guidelines the facility failed to label multi dose oral inhalers with resident names and failed to record opened dates on multi dose oral inhalers and on an insulin pen on 2 of 3 medication carts (300 and 400 hall medication carts) reviewed for medication storage. Findings included: 1. Review of the manufacturer's guidelines revealed to discard the Stiolto Respimat, the Striverdi Respimat, and the Combivent Respimat 3 months after the first use. The guidelines revealed the Trelegy oral inhaler should be discarded 6 weeks after opening and to record the opened date on the label of the inhaler. The Advair Diskus was to be discarded 30 days after removal from the protective foil pouch, and to discard Incruse 6 weeks after opening and to record the opened date on the inhaler. An observation of the 300-hall medication cart conducted on 02/19/23 at 4:15 PM with Nurse #3 revealed: two Stioloto Respimat oral inhalers (prescribed for treatment of chronic lung disease) that were not labeled with resident names. Further observations of the 300-hall medication cart on 02/19/23 at 4:15 PM with Nurse #3 revealed no opened dates on a Stioloto Respimat oral inhaler, a Trelogy Ellipta oral inhaler, and a Combivent oral inhaler (each prescribed for treatment of chronic lung disease) that were used with no opened dates.	F 761	F 761 Label/Store Drugs and Biologicals Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 2/19/23, (who) discarded 2 multi-dose oral inhalers with no resident names labeled and 3 multi-dose oral inhalers with no open date labeled from the 300 Hall medication cart. On 2/19/23, (who) discarded 1 insulin pen with no open date labeled on the 400 Hall medication cart.	

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F 761	Continued From page 69 During an interview conducted with Nurse #3 on 02/19/23 at 4:15 PM she stated she was not aware the inhalers on the medication cart were not dated when they were opened. She acknowledged the inhalers had been used and stated the nurse who opened the inhaler should have recorded a date. She stated the nurses conducted routine checks of the medication carts to make sure all medications were labeled and dated and stated the inhalers were missed. 2. The manufacturers guidelines revealed the Tresiba insulin flex pen can be stored at room temperature for a maximum of 8 weeks (56 days) then discard. An observation of the 400-hall medication cart conducted on 02/19/23 at 4:30 PM with Nurse #4 revealed: a Striverdi Respimat oral inhaler, an Advair discus inhaler that was out of the foil pouch, and an Incruse oral inhaler that were used with no opened dates. Further observation revealed a Tresiba insulin flex touch pen that had been used with no opened date recorded. During an interview conducted with Nurse #4 on 02/19/23 at 4:30 PM she stated she was not aware the inhalers or the insulin pen on the medication cart were not dated when they were opened. She stated she had not administered the inhalers or the insulin during her shift and had not checked the medications for opened dates. She acknowledged the inhalers and the insulin pen had been used and stated they should have been dated once the medications were opened.	F 761	On 3/16/23, the administrative nurses initiated an audit of all medication carts to include 300 and 400 hall medication carts. This audit is to ensure all medications stored in medication carts were labeled with resident names and/or labeled with open/expiration date per facility protocol. All identified areas of concern were addressed by the administrative nurses during the audit to include removal of medication not labeled with the resident name and/or an open/expiration date. The audit will be completed by 4/3/23. On 3/16/23, the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding Medication Storage and Labeling with emphasis on (1) ensuring medications to include multi-dose inhalers are labeled with the resident name (2) ensuring all medications to include multi-dose inhalers and insulin pens have been labeled with the date opened and/or expiration date. This in-service will be completed by 4/3/2023. After 4/3/2023, any nurse or medication aide that has not yet received this in-service will receive the in-service prior to the next scheduled shift. All newly hired nurses and medication aides will receive this in-service during orientation regarding Medication Storage and Labeling. All medication carts to include medication carts on 300 and 400 halls, will be monitored by the Unit Facilitator and RN Supervisor weekly x 4 weeks, then	

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F 761	Continued From page 70 An interview was conducted on 02/23/23 at 11:00 AM with the Director of Nursing (DON). He stated the medication carts were checked daily by the nurses to ensure medications were labeled and dated. He indicated the oral inhalers and the insulin pen had shortened expiration dates and should be labeled and dated when opened.	F 761	monthly x 1 month, utilizing the Medication Cart Audit Tool to ensure all medications to include but not limited to multi-dose inhalers insulin pens are labeled with the resident's name and have open and/or expiration dates when indicated per facility protocol. The nurses and/or medication aides will be immediately re-trained by the Unit Facilitator and RN Supervisor for any identified areas of concern. The DON will review the Medication Cart Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will forward the results of the Medication Cart Audit Tool to the Executive Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months to review, address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring.	
F 812 SS=E	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	F 812		4/3/23

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F 812	Continued From page 71 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to discard milk cartons and nutritional supplements that were stored for use past the use by dates in 1 of 1 walk in refrigerators observed for food storage. This practice had the potential to affect all residents who consumed these products. The facility also failed to repair broken floor tiles in the kitchen adjacent to the dishwasher, and repair cracked, peeling paint hanging from the ceiling tiles above 2 of 3 the food preparation tables reviewed for sanitation. Findings included. 1)The initial tour of the kitchen conducted on 02/19/23 at 11:30 AM revealed 3 crates of milk cartons. One crate contained 32 milk cartons and each carton had a use by date of 02/17/23, a second crate contained 15 milk cartons each with a use by date of 02/18/23, a 3rd crate contained 50 milk cartons each with a use by date of 02/18/23. This was observed in the walk-in refrigerator. There was no label on the crates indicating the milk cartons had expired. Further observations conducted on 02/19/23 at 11:30 AM revealed 4 cases of nutritional	F 812	F 812 Food Procurement, Store/Prepare/Serve- Sanitary Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

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F 812	Continued From page 72 supplements containing 27 supplements per case. Two of the cases had a use by date of November 2020, and 2 cases had a use by date of January 2021. This was observed in the walk-in refrigerator. During an interview conducted on 02/19/23 at 12:00 PM with the Assistant Dietary Manager he stated the milk company comes to pick up the milk cartons and stated they should have already picked them up since they were past the use by date. He stated he would remove the crates from the refrigerator so that staff would not use them. He stated there were currently no residents who received the nutritional supplements but stated the 4 cases should have been removed from the walk-in refrigerator by the use by date and he didn't know why they remained in the walk-in refrigerator. During an interview with the Dietary Manager on 02/23/23 at 1:00 PM she stated the milk cartons, and the nutritional supplements should have been removed from the walk-in refrigerator by the use by dates. She stated staff had been instructed to check for expired foods daily and these items were missed. She indicated further education on food storage would be provided to staff. During an interview conducted on 02/23/23 at 2:00 PM with Administrator #1, he stated the kitchen staff should have removed the milk cartons and the nutritional supplements from the walk-in refrigerator by the use by dates and to prevent the items from being served to residents. 2) During the initial tour of the kitchen on 02/19/23 at 11:30 AM observations revealed broken floor tiles adjacent to the dishwasher. The	F 812	On 2/19/23, the Dietary Manager discarded all items stored past the “use-by” date in the walk-in refrigerator to include nutritional supplements. All crates of expired milk cartons were returned to the supplier on 2/20/23. On 2/21/23, the Regional Vice President (RVP) contacted Hillco, ltd. Contractors and scheduled for repairs to be addressed in the kitchen with ceiling tiles and flooring. On 2/21/23, the Maintenance Director initiated repair of ceiling tiles in the kitchen to include tiles above the food preparations tables. Repairs will be completed by 4/3/23. On 2/21/23, the Maintenance Director initiated repair of broken floor tiles in the kitchen. Repairs will be completed by 4/3/23. On 3/16/23, Accounts Receivable (AR) under the supervision of the Director of Nursing completed an audit of all items in the walk-in refrigerator. This audit was to ensure all items in the walk-in refrigerator were labeled with an “open date” or a “use by date” and that all items were discarded after the “use-by” date per facility protocol. All areas of concerns identified during the audit were immediately addressed by the Administrator to include education of staff and/or discarding items without an “open date” and/or a “use-by” date. On 3/16/23, the Accounts Receivable	

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F 812	Continued From page 73 broken tiles contributed to water buildup in the floors causing an unsafe environment due to the water pooling in the broken areas of the tiles. 3) Further observations of the kitchen on 02/19/23 at 11:30 AM revealed the ceiling tiles had chipped and peeling paint hanging from the ceiling throughout the kitchen and above 2 of the food preparation tables, there were also large areas of stained and rusted tiles throughout the ceiling. An interview was conducted on 02/20/23 at 1:00 PM with the Dietary Manager. She stated she had notified the Maintenance Director on multiple occasions over at least the past year regarding the ceiling tiles and floor tiles needing to be replaced or repaired. She stated the broken floor tiles led to water build up in the cracks and water already pooled in the floor in that area because the broken tiles were at the sink and dishwasher. She stated the floor in that area stayed wet and indicated it was a safety hazard. An interview was conducted on 02/20/23 at 3:00 PM with the Maintenance Director. He stated he was aware of the ceiling and floor tiles needing repair but stated he had not had time to focus on those areas. He stated he continued to work on daily maintenance issues that were entered into the work order system and just had not taken the time to address the kitchen. He stated he planned to start replacing the ceiling tiles tonight after the kitchen closed and would start on the floor tiles. An interview was conducted on 02/22/23 at 4:00 PM with the Regional Vice President. He stated he conducted a walk-through of the kitchen and agreed the ceiling and floor tiles needed to be	F 812	(AR) under the supervision of the Director of Nursing initiated an audit of kitchen areas in need of repair to include but not limited to broken floor tiles and cracked/peeling paint. The Maintenance Director will address all concerns identified during the audit to include replacing floor tiles or repair of cracked/peeling paint when indicated. The audit will be completed by 4/3/23. On 3/16/23, the Director of Nursing initiated an in-service with the Dietary Manager and dietary staff regarding (1) Labeling and Storage of Food Items with emphasis on labeling all food items in the walk in refrigerator with an “open date” if opened or a “use by date” or removal of expired food items per facility protocol to ensure food service safety (2) Work Orders with emphasis on initiating work orders for any area in need of repair to include but not limited to cracked tiles or cracked/peeling paint to ensure items are in good repair and working order. In-service will be completed by 4/3/2023. All newly hired Dietary Staff will receive this in-service during orientation regarding Labeling and Storage of Food Items and Work Orders. The AR will complete an audit of the walk-in refrigerator 3 times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure all items in the walk-in refrigerator are labeled with an “open date” when opened or a “use by date” per facility protocol. The Dietary Manager will	

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F 812	Continued From page 74 replaced. He stated he instructed the Maintenance Director to begin replacing the ceiling tiles today and indicated the floor tiles would be replaced as well.	F 812	address all concerns identified during the audit to include discarding items not labeled per facility protocol and re-education of staff. The Administrator will review the Kitchen Audit Tool 3 times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month to ensure all concerns are addressed. The AR will complete an audit of the kitchen to include floor files and ceiling tiles 3 times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure the kitchen area environment is safe and free from chipped paint and/or missing or broken ceiling and floor tiles. The Administrator will address all concerns identified during the audit to include notification of the Maintenance Director to address and repair areas of concern and/or re-education of staff. The Administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Kitchen Audit Tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Kitchen Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 867	Continued From page 75	F 867		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		4/3/23

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F 867	Continued From page 76	F 867		

facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and

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F 867	Continued From page 77 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assurance & Performance Improvement Program (QAPI) failed	F 867	F 867 QAPI/QAA Improvement Activities Premier Nursing and Rehabilitation	

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F 867	Continued From page 78 to maintain implemented procedures and monitor interventions that the committee put into place following a recertification and complaint investigation of 01/07/22 and complaint investigations of 06/30/22 and 12/23/20. This was for 3 deficiencies that were originally cited in the areas of accurate coding of the Minimum Data Set assessments (F641), developing/implementing comprehensive care plans (F656), and drug regimen reviews/report irregularities (F756) and were subsequently recited on the current recertification survey of 03/03/23. The continued failure during 2 or more federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Findings included: This tag is cross referenced to: a. F641: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 31 residents (Resident #127) reviewed for MDS accuracy. During the annual recertification and complaint survey of 01/07/22, the facility failed to accurately code a MDS assessment for wander/elopement and failed to accurately code a MDS assessment for urinary bladder and bowel. During an interview conducted on 02/23/23 at 4:00 PM with the Director of Nursing (DON) he stated the corrective actions regarding the accuracy of MDS assessments did not work due to changes in staffing and further training and education would be provided to the MDS nurse.	F 867	Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/16/23, the Regional Nurse Consultant initiated an audit of previous citations and action plans from 12/23/2020-3/3/2023 including F 641-Minimum Data Set (MDS) Coding Accuracy, F 656-Developing/Implementing Comprehensive Care Plans, and F 756-Drug Regimen Reviews/ Report Irregularities. Action plans were revised and updated and presented to the Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing (DON) for any	

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F 867	Continued From page 79 The DON stated the plan of correction for the repeated deficiencies would be implemented and discussed in the next QA meeting scheduled for next week. He stated staff needed further training and education, and audits would be implemented after changes were made. b. F656: Based on record review and staff interviews the facility failed to develop and implement a comprehensive person-centered care plan that addressed measurable goals and interventions for 4 of 6 residents (#8, #77, #123 and #127) reviewed for care planning. During the annual recertification and complaint survey of 01/07/22, the facility failed to develop a comprehensive care plan for a resident with a known history of wandering. During a complaint survey on 12/23/20, the facility failed to implement a resident's care plan when staff transferred a resident from her wheelchair to her bed without using a mechanical lift. During an interview conducted on 02/23/23 at 4:00 PM with the DON, he stated the corrective actions regarding developing and implementing a comprehensive care plan did not work due to changes made in staffing and continued education was needed for the nurses. c. F756: Based on observations, record review, Nurse Practitioner, Consultant Pharmacist, and staff interviews the facility failed to implement a pharmacy recommendation which resulted in a resident (Resident #55) not receiving her daily dose of Victoza (a non-insulin medication to treat diabetes) for 21 days for 1 of 5 residents reviewed for unnecessary medications.	F 867	concerns identified. The Regional Nurse Consultant will address all concerns identified during the audit to include but not limited to the education of staff. The audit will be completed by 4/3/2023. On 3/17/2023, the Regional Nurse Consultant initiated an in-service with the administrator, Director of Nursing (DON), and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of action plans, monitoring tools, the evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include infection control. The in-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. This in-service will be completed by 4/3/2023. All newly hired Administrators, DONs, Assistant DONs, and QA Nurses will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include MDS coding accuracy, care plan development and implementation, and drug regimen reviews/report irregularities will be taken to the QAPI committee for review monthly x 2 months by the Quality Assurance (QA) Nurse. The QAPI committee will review the data and determine if plans of correction are being followed, if changes	

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F 867	Continued From page 80 During the complaint investigation survey on 06/30/22, the facility failed to act upon the Consultant Pharmacist's new admission medication regimen review (MRR) that identified Metformin (a medication used for the treatment of diabetes) 1000 milligrams twice daily listed on the hospital discharge summary was omitted from the facility's physician orders resulting in 12 missed doses of the medication reviewed for diabetic care. Resident #3 was unresponsive to verbal stimuli on 05/25/22 at 9:30 AM. Resident #3 was cool and clammy to touch with a blood sugar of "HI" indicating an abnormal reading with a level greater than 400 milligrams per deciliter. Resident #3 required hospitalization in the intensive care unit with a diagnoses of hyperglycemic state with a blood sugar reading of 711 milligrams per deciliter. During an interview conducted on 02/23/23 at 4:00 PM with the DON, he stated the unit facilitator in charge with managing pharmacy recommendations should receive orders back from the physician within 7 days, then the unit manager had 10 days to complete the recommendations. He stated more education was needed for the unit manager regarding the process.	F 867	in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the QAPI committee will be documented monthly at each meeting by the QA Nurse. The Regional Nurse Consultant will ensure the facility is maintaining an effective QA program by reviewing the QAPI committee quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include MDS coding accuracy, care plan development and implementation, and drug regimen reviews/report irregularities and all current citations and QA plans are followed and maintained quarterly x2. The Regional Nurse Consultant will immediately retrain the Administrator, DON, ADON, and QA Nurse for any identified areas of concern. The results of the monthly QA committee meeting will be presented by the Administrator to the QAPI Committee quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	