STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 06/06/2021 through 06/11/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XMAL11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 06/06/2021 through 06/11/2021. Event ID# XMAL11. 35 of the 76 complaint allegations were substantiated resulting in deficiencies. A follow up survey was also conducted during this survey. Event ID#5CX912.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		7/16/21

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

Electronically Signed | 07/05/2021

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff, and family interviews, the facility failed to maintain resident's dignity when a complete bath was not given on a regular basis, and staff commented on the Resident's body odor and a staff member fussed about the Resident reporting the lack of a bath (Resident #197), also, when a resident was dressed in a shirt and a bedsheet for an outside visit with their family (Resident #41) for 2 of 8 residents reviewed for dignity (Resident #197 and Resident #41). Findings included: 1. Review of the medical record revealed Resident #197 was admitted 5/23/2019 with	F 550	Universal Healthcare of Fuquay Varina acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on June 6-11, 2021. Universal Healthcare of Fuquay Varina response to the Statement	

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F 550	Continued From page 2 diagnoses of Diabetes Mellitus, End Stage Renal Disease and Depression. The Annual Minimum Data Set (MDS) dated 4/6/2021 noted Resident #197 was cognitively intact and required total assistance for all daily care with one to two persons' help. Resident #197 was noted to have no functional vision and hand contractures. The Care Area Assessment noted a focus of Activities of Daily Living (ADL) care and this area went to care plan. The care plan dated 4/29/2020 noted Resident #197 required assistance for bathing related to bilateral hand contractures and no functional vision. Interventions included assist with perineal cleansing as needed. This was the role of Nursing/Nursing Assistant. On 6/6/2021 at 3:20 PM, Resident #197 stated there was only one Nursing Assistant (NA#1) who would bathe his private area and she was working that day. Resident #197 said "NA #1 told me that I smelled when she washed me. I was so embarrassed, because I knew it was true." Resident #197 indicated he had told someone that NA#2 did not wash him, and that NA #2 had come into his room and fussed at him for telling that. In an interview on 6/6/2021 at 3:35 PM, NA #1 stated when she had a day off and returned to work, she could tell that Resident #197 had not had a complete bath the day before, because he would smell bad. On 6/8/2021 at 10:31 AM, Resident #197 was observed getting a bed bath by NA #1. NA #1 was noted to be thorough and had a good	F 550	of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Universal Healthcare of Fuquay Varina reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F 550 1. The facility failed to maintain Resident #197 dignity when a complete bath was not given on a regular basis, and staff commented on Resident #197 body odor and also when Resident #41 was dressed in a shirt and bedsheet for an outside appointment. Resident #197 received bed bath upon notification. Resident #41 is no longer in the facility. 2. All current residents have the potential to be affected by the alleged practice. An an audit was completed by MDS Coordinator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on all Alert and Oriented residents to ask what their preferred shower and/or bath days. For the residents that are unable to express their preference, their Responsible Party and/or Power of Attorney were asked their preferred shower day and/or bath days by MDS Coordinator, DON, and ADON. This audit will be completed by 7/7/2021. Changes made to shower schedule as needed.	

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F 550	Continued From page 3 conversation with the Resident while she bathed him. On 6/9/2021 at 11:48 AM, NA #2 was interviewed and stated she always tried to give her residents a good bath. "I wash them all over, I don t know why he told that on me." NA #2 noted she usually worked the middle assignment of the hall, and not the area of Resident #197's room. In an interview on 6/9/2021 at 12:15 PM, the Director of Nursing (DON) stated Resident #197 told her that NA #2 did not wash him completely. The DON stated she did not file a grievance because the former Administrator told her not to, that the Nursing Assistants would be re-educated. The DON stated that the Nursing Assistants were spoken to but did not say there was an in-service. On 6/10/2021 at 12:04 PM the Administrator stated he expected residents to get a bath daily if they wanted one and showers as scheduled. 2. Resident #41 was admitted to the facility on 03/27/2021 with diagnoses which included cerebral infarction, type II diabetes and hypertension. A review of Resident #41's admission Minimum Data Set (MDS) dated 04/20/2021 revealed the resident had moderate cognitive impairment and required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. A review of Resident #41's care plan dated 04/06/2021 revealed the Resident was care planned for assistance for eating, mobility, transfers, dressing, grooming and personal hygiene related to weakness. Interventions included staff assistance with Activities of Daily	F 550	Social Worker/Laundry Supervisor conducted an audit to ensure all residents had adequate clothing. Residents found not to have adequate clothing, their responsible party will be contacted about the need for clothing or the facility will assist in providing needed clothing. This audit will be completed by 7/7/2021. 3. All nursing staff educated by DON and/or nurse managers regarding expectations that the residents shower/bed bath is completed on the designed day and the process if a resident refuses a shower/bed bath. Nursing staff were also educated on properly dressing the resident. This education will be completed by 7/9/2021. Nurse managers will audit the weekly shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath are scheduled per their preference. Audit will be conducted weekly x 12 weeks. Nurse managers/designee will monitor resident□s leaving for appointments to ensure that they are adequately dressed. Director of Nursing will review the results of the weekly audits to ensure any issues identified are corrected. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance	

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F 550	Continued From page 4 Living (ADLs). A goal for Resident #41 was the resident would be clean, dry and appropriately dressed until the next review. A review of the facility's grievance log for the month of April 2020 revealed a grievance was logged by a family member on 04/17/2021 on behalf of Resident #41 for bringing the resident outside for visitation while only wearing a short-sleeved shirt, no pants and a bed sheet wrapped around his lower body. The grievance also noted the weather that day was very cool and breezy, and the family member was worried Resident #41 would catch a cold from not being dressed appropriately for the weather. A review of the facility grievance form and follow-up letter mailed to Resident #41's address revealed the facility staff "did not dress Resident #41 appropriately for a family visit on 04/17/2021." The grievance letter included "the facility had spoken to the nursing staff regarding the overall appearances of the residents." The administrative staff member assigned the grievance was no longer employed by the facility. A review of the facility's town hall meeting dated 04/19/2021 revealed three staff signatures from the nursing department and a topic of "please ensure residents are dressed and ready for appointments." An interview with Resident #41's family member on 06/07/2021 at 5:26 pm revealed she went to the facility on 04/17/2021 for a scheduled visit with Resident #41 and when she arrived, a staff member presented at the front entrance and informed her she would not be able to visit because her visit had been cancelled. She stated	F 550	Performance Improvement (QAPI) committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing and Assistant Director of Nursing	

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F 550	Continued From page 5	F 550		

she had not been previously informed by the facility that her visit had been cancelled but still wanted to visit with Resident #41. She stated the staff agreed to let her visit and went back inside to get the resident. When Resident #41 arrived outside assisted by a staff member, he was wearing only a short-sleeved shirt, no pants and a bed sheet covering his lower body. She stated she informed the staff member Resident #41 was not dressed appropriately or warm enough for the cold weather that day. She stated the staff member called the then acting Administrator to inform her about her concerns.

A review of the facility's nursing assignment sheets for 04/17/2021 and 04/18/2021 revealed the named nursing staff assigned to Resident #41 during the 7am-7pm shift were no longer working at the facility.

Attempts were made to contact the staff members who were working on 04/17/2021 and 04/18/2021 on the 7am-7pm shift without success as they no longer employed at the facility.

An interview with the Social Worker on 06/08/2021 at 3:10 pm revealed Resident #41's family had scheduled a visit for 04/17/2021 and 4/18/2021 and stated the facility receptionist called the listed family member the day before the visit, 04/16/2021, to confirm the upcoming visit. She stated the receptionist confirmed the visit with the family member for 04/18/2021 but didn't realize that a different family member had scheduled the visit for 4/17/2021. She stated the receptionist thought the 04/17/2021 visit was logged in error and cancelled it from the facility calendar. She further stated on 04/17/2021, Resident #41's family member arrived at the

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F 550	Continued From page 6 facility for the scheduled visitation but was told her visit had been cancelled. The family member was upset and expected to still visit with Resident #41. She stated that because of the facility miscommunication error and due to the urgency of getting Resident #41 outside for the visit, the staff did not have him appropriately dressed for the visit. An interview with the Director of Nursing (DON) on 06/08/2021 at 3:27 pm revealed she was aware of the grievance that was filed and remembers the family member being "not happy" about Resident #41's attire when he arrived for their visit. She was new to the role of the DON since March 2020 and planned to conduct education with the nursing staff on dressing the residents but hadn't gotten around to doing so. She stated the staff should get the residents dressed appropriately for visits and appointments. An interview with the Administrator on 06/08/2021 at 3:40 pm revealed he was not working at the facility at the time of the incident as he was an Interim Administrator. He stated he was able to read over the grievance and the grievance letter that was sent to the family. He stated there had not been a plan of correction for the incident but knew the topic of dressing residents appropriately had been discussed at a staff "town hall meeting" on 04/19/2021. An additional interview with the Administrator on 06/11/2021 at 11:25 am revealed the facility should ensure all residents were always dressed appropriately for appointments and visitation.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		7/16/21

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F 554	Continued From page 7 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sample resident (Resident #347) who was observed to have medications at bedside. The findings included: Resident #347 was admitted to the facility on 4/26/21. Her cumulative diagnoses included osteoporosis and anemia. A review of Resident #347's admission orders dated 4/26/21 included the following medications, in part: --Centrum Silver tablet to be given as one tablet by mouth daily for supplement; --Caltrate 600 + D tablet to be given as one tablet by mouth daily every morning for supplement; and, --324 milligrams (mg) enteric coated ferrous sulfate (iron) tablet to be given as one tablet by mouth daily with breakfast for anemia. The physician orders did not include an order for the resident to self-administer any of her medications. A review of the resident's baseline care plan dated 4/26/21 was conducted. The baseline care plan did not address the self-administration of medications.	F 554	F554 1. The facility failed to determine whether the self-administration of medications was clinically appropriate for Resident #347 was observed to have medications at bedside. Resident #347 is no longer at the facility. 2. DON and ADON completed a facility tour to ensure medications were not left at the bedside for current facility residents. This audit was completed on 6/29/2021. 3. All licensed nurses and medication aides will be educated on not leaving medications unattended at the bedside of the resident. Medications are to be given then, if resident does not want to take medications at the appropriate time, staff is to discard of the medication appropriately and document. In person or via telephone by the Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by 7/9/2021. Any Licensed Nurse and/or medication aide that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by midnight	

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F 554	Continued From page 8 Resident #347's admission Minimum Data Set (MDS) dated 5/3/21 revealed the resident had intact cognitive skills for daily decision making. She was assessed as being totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating. A comprehensive, individualized care plan was not completed for Resident #347. Further review of the resident's medical record revealed no assessments were completed for the self-administration of her medications. An observation was conducted on 6/6/21 at 11:50 AM as Resident #347 was lying in bed. She was awake and alert. Her breakfast meal tray was observed to be placed on a counter across the room from her bed. A medicine cup containing three tablets was observed to be placed on the bedside table within reach of the resident. The tablets included one white oval tablet, one lavender oval tablet, and one round, reddish-brown tablet. An interview was conducted with the resident at the time of this observation. During the interview, the resident was asked about the tablets observed in the medicine cup. She reported they were her vitamins and stated she could not take them on an empty stomach because they would make her sick. When asked if the nurse always left these medications for her to take on her own, she stated, "Yes." An interview was conducted on 6/6/21 at 12:11 PM with Nurse #6. Nurse #6 was identified as the hall nurse assigned to administer the morning medications to Resident #347. During the interview, the observation and interview with the	F 554	7/9/2021. Effective 7/5/2021, all Licensed nurses, including Agency staff, will be educated in orientation in person by Staff Development Coordinator, Director of Nursing and/or Assistant Director of Nursing on not leaving medications unattended at the bedside of the resident. Medications are to be given then, if resident does not want to take medications at the appropriate time, staff is to discard of the medication appropriately and document. Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will audit 20 residents per week X 4 weeks, 15 residents per week X 4 weeks, and 10 residents per week x 4 weeks to ensure no medications are left at the bedside. Audits will be conducted on weekends and all shifts. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 554	Continued From page 9	F 554		

resident were discussed. Nurse #6 stated, "She must have put them in her mouth and spit them out ...I probably should have stayed in there to make sure she swallowed them." A follow-up interview was conducted on 6/6/21 at 2:10 PM with Nurse #6. Upon inquiry, the nurse reported the medications left in the medicine cup for Resident #347 were "her vitamins." When asked what the nurse usually did with a medication cup after medications were administered to a resident, Nurse #6 stated she typically threw it in the room's trash. However, she added, "sometimes they like to keep them."

An interview and observation was conducted on 6/6/21 at 2:15 PM with Medication Aide #1 as she was standing at the medication cart containing Resident #347's medications. Resident #347's medications were observed to confirm the identity of the three tablets observed to be left in the medicine cup in her room. The tablets were identified as one Centrum Silver multivitamin (white oval tablet), one Caltrate 600 + D (lavender oval tablet), and one - 324 mg enteric coated ferrous sulfate tablet.

An interview was conducted on 6/9/21 at 8:57 AM with the facility's Director of Nursing (DON). During the interview, the observation of three tablets left in a medicine cup in Resident #347's room and the resident's interview conducted on 6/6/21 at 11:50 AM were discussed. With regards to the self-administration of medication and/or leaving medications at a resident's bedside, the DON stated, "The nurses know they aren't supposed to do that." The DON reported the facility needed to follow a process to assess a resident's ability for the self-administration of medications. If the resident was assessed as able

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F 554	Continued From page 10 to self-administer medications, he or she would have to be educated on the administration and be able to do a return demonstration. Additionally, the DON stated a resident's self-administration of medications would include care planning and a physician's order as part of this process.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to accommodate the needs of one of four residents reviewed (Resident #61) when the call bell was not within the reach of the Resident. Findings included: A review of the medical record revealed Resident #61 was admitted 4/9/2019 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Rheumatoid Arthritis with pain in joints of right and left hand, with contractures. The Annual Minimum Data Set (MDS) dated 2/8/2021 noted Resident #61 was cognitively intact and required extensive to total assistance for all Activities of Daily Living (ADLs) with the help of one to two persons. The Care Area Assessment indicated a focus of ADL function and this went to care plan.	F 558	F558 1. Facility failed to accommodate the needs of Resident #61 when the call bell was not within reach. Maintenance Director provided Resident #61 with a call bell clip to ensure call bell was within reach. 2. Administrator and Maintenance Director completed a facility tour to ensure that call bells were in reach for current residents. This was completed immediately upon notification of call bell issue of Resident #61. 3. All facility staff were educated on the expectation that residents call bells are in reach. The Administrator, Director of Nursing, Nurse Managers and Facility	7/16/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 11 The care plan dated 4/8/20 noted a focus of Resident #61 has an ADL self-care deficit related to her decrease functional mobility secondary to her diagnoses of Rheumatoid Arthritis and COPD. Interventions included: Ensure resident's call bell is kept within her reach. On 6/6/2021 at 12:15 PM, Resident #61 was observed at the bedside, in her wheelchair, in her room. When asked where her call bell was, the Resident stated it was beside her bed, but she could not reach it if she was up in the wheelchair. The call bell was observed on the side of the bed which was against the wall tied to the string of the light fixture. If the Resident was in bed, she could reach the call bell, but not if she was in the wheelchair. Resident #61 stated if she needed to use the call bell, she would ask her roommate to turn her call bell on. As for the call bell in the bathroom, Resident #61 stated it was hard for her to get her wheelchair over the raised strip on the bathroom floor at the doorway. On 6/7/2021 at 9:30 AM, Resident #61 was observed in bed. At 11:30 AM the Resident was up in her wheelchair in her room at the bedside and the call bell was observed tied to the string of the light fixture. On 6/9/2021 at 11:30 AM, Resident #61 was observed in bed with her breakfast tray on the overbed table. NA #4 was in the hallway and asked if she could assist Resident #61. NA #3 stated she was on her way to get the Resident up. NA #3 stated she did not have any problem getting her work done. At 1:00 PM the Resident was noted to be up in the wheelchair with the call bell tied to the string of the light fixture. Resident	F 558	Ambassadors will conduct an audit to ensure that calls bells are in reach. This audit will be conducted 5 x per week x 12 weeks. Administrator will review the results of the weekly audit to ensure any issues identified are corrected. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI)committee by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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	345561	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 558	Continued From page 12 #61 tried to lean over the bed but was unable to reach the call bell. "I just can't reach it" she stated. At 1:30 PM on 6/11/2021, the Administrator stated that all residents should have access to their call bells. When advised Resident #61 could not reach her call bell, the Administrator stated, "That's not good."	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		7/16/21

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F 578	Continued From page 13 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to obtain a physician's order and maintain an accurate Advance Directive for 2 of 2 residents reviewed for Advance Directives (Resident #44 and Resident #9). The findings included: 1. Resident #44 was admitted to the facility on 3/29/21 with a diagnosis of hepatic failure and Type 2 Diabetes Mellitus. The Admission Minimum Data Set (MDS) dated 4/5/21 revealed resident #44 was cognitively intact. Record review revealed a physician order dated 4/21/21 which read full code. A second physician order reviewed was dated 5/20/21 which read admit to hospice services. Resident #44's electronic record revealed an	F 578	F578 1. Facility failed to obtain a physician's order and maintain an accurate Advance Directive for resident #44 and #9. Resident #44 no longer at the facility. Resident #9 Advance Directive was corrected on 6/10/2021. 2. An audit was conducted on all current residents to ensure accuracy of code status by the Director of Nursing, Assistant Director of Nursing, and Unit managers. This audit was completed by 7/7/2021. 3. Regional Nursing Consultant educated Director of Nursing, Assistant Director of Nursing, Unit Managers, and Social Worker on ensuring residents have the accurate code status upon admission. The code status it to be reviewed at least quarterly, at a significant change in condition, and annual. Education	

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F 578	Continued From page 14 Advance Directive of attempt CPR. Resident #44's paper chart revealed a Full Code Agreement dated 4/21/21 located in the front of the chart. On 6/10/21 at 3:44 PM a telephone interview with the hospice admissions nurse revealed Resident #44 was admitted to hospice services and her Advanced Directive was changed to Do Not Resuscitate (DNR). On 6/11/21 at 8:08 AM an interview was conducted with Resident #44's family member and they stated Resident #44 was a DNR. A physician order was not located in the chart to change Resident #44's Advance Directive to DNR. An interview was conducted with the Social Worker on 6/11/21 at 8:30 AM. She stated it was the nurse's responsibility to change the Advanced Directive if it was changed during the resident's stay if an order was written. On 6/11/21 at 9:00 AM, Nurse #4 was interviewed, and she stated if she received an order for an Advance Directive change, she would make sure the chart reflected the new order. An interview with the DON on 6/11/21 at 9:40 AM was conducted and she stated getting an order and updating Resident #44's chart got dropped and it fell through the cracks. She stated the Advance Directive should have been addressed by nursing when Resident #44 was placed on Hospice.	F 578	completed by 7/7/2021. Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or designee will audit 20 residents per week x 4 weeks, 15 residents per week x 4 weeks, and 10 residents pe week x 4 weeks to ensure accuracy of code status. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI)committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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2. Resident #9 was admitted to the facility on 10/05/2020 with a diagnosis of hypertension, generalized weakness and dementia without behavioral disturbance.

A review of the quarterly Minimum Data Set (MDS) dated 04/19/2021 revealed Resident #9 was cognitively intact.

A review of Resident #9's electronic medical record revealed a physician order on 10/05/2021 which read full code. The section of Advance Directives in the electronic medical record read attempt Cardiopulmonary Resuscitation (CPR).

A review of Resident #9's paper chart revealed admission orders dated 10/05/2020 were written for Resident #9 for a full code.

A review of the care plan conference notes dated 02/19/2021 revealed a meeting was requested by Resident #9's family member for multiple concerns, including her Do Not Resuscitate (DNR) status. Resident's family member informed the Interdisciplinary Team (IT) of Resident #9's DNR status and asked that the facility update Resident #9's medical record as a DNR. The IT care plan notes written by the Social Worker indicated nursing would correct this.

An interview with the Social Worker on 06/09/21 at 04:19 PM revealed she attended the IT care plan meeting for Resident #9 on 02/19/2021 and stated the nursing department representative who attended the IT meeting would have been responsible for taking steps to update the DNR status in Resident #9's medical chart.

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F 578	Continued From page 16 An interview with the Director of Nursing (DON) on 06/09/21 04:31 revealed she attended the IDT meeting on 02/19/2021. At that time, she was not the DON and was the MDS Nurse. She stated she would have communicated the DNR information to nursing. She stated she didn't remember who she communicated the information to after the meeting. She stated once she communicated the information to nursing there would not have been any other follow up on her part to see if the DNR request had been updated. She stated the medical chart should have been updated as requested. An interview with the Administrator on 06/09/2021 at 4:46 pm revealed the facility should update medical records for all residents as needed including for DNR status.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		7/16/21

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F 580	Continued From page 17 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and record review, the facility failed to notify a resident ' s representative of medication changes for one of four residents reviewed for notification (Resident #70). Findings included:	F 580	F580 1. Facility failed to notify a resident□s representative of medication changes for resident #70. Medications for resident #70 was reviewed with representative on 6/29/2021.	

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F 580	Continued From page 18 Review of the medical record revealed Resident #70 was admitted 6/13/2020 with diagnoses that included dementia, coronary artery disease and Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 4/6/2021 indicated Resident #70 was severely impaired for cognition and had rejection of care. The MDS noted Resident #70 required limited to extensive assistance for all daily care with the help of one to two persons. The Care Area Assessment focused on Dementia, behaviors, nutrition and psychotropic drug use. A review of orders dated 7/20/2020 indicated Resident #70 was to receive a diuretic (to help rid the body of fluid) 20 milligrams (mg) by mouth every day for edema (swelling due to fluid). Review of the nurse progress notes revealed no documentation of notification of the resident representative for new medication. The discontinue order was for 11/10/2020. There was no documentation in the nurse progress notes for notification of the resident representative that the medication was discontinued. Review of orders dated 8/12/2020 indicated Resident #70 was to be given 2 puffs of an inhaler every 4 hours for shortness of breath, hypoxia (decrease in oxygen). The order was discontinued on 12/23/2020. On 12/23/2020 a new order was written for the same inhaler with 2 puffs given every 6 hours as needed for shortness of breath/hypoxia. The medication was discontinued on 5/20/2021. Review of the nurse progress notes for the orders for the inhaler, the discontinuing of the inhaler and the new order for the inhaler revealed no notification of the resident	F 580	2. An audit was conducted for current facility residents for the last 30 days of medication changes to ensure notification was completed by the Director of Nursing, Assistant of Director of Nursing, and Unit managers. This audit will be completed by 7/7/2021. 3. All Licensed nurses will be educated by the ADON/SDC or DON on notifying the RP and MD and documenting notification. This education will be completed by 7/9/2021. Any Licensed nurses that has not been educated will not be allowed to work until they receive education in- person or via telephone by Director of Nursing and/or designee. Effective 7/7/2021, all Licensed nurses will be educated in orientation on notifying the RP and MD and documenting notification. Effective 7/7/2021, all medication changes will be reviewed in morning clinical meeting (Monday-Friday) to ensure that proper RP and MD notification was made. The review will be documented on the clinical morning meeting worksheet. Director of Nursing and/or Assistant Director of Nursing will audit the clinical morning worksheet to ensure proper RP and MD notification was made x 12 weeks. 4. Data obtained during the audit	

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F 580	Continued From page 19 representative of the order or the discontinuation of the medication. In an interview on 6/6/2021 at 1:00 PM, the family member stated there had been no notification of medication changes and the family member only became aware during the 10/2020 care plan meeting there had been medication changes. The family member stated there had been no notification since that October care plan meeting that medications had been changed. On 6/10/2021 at 10:30 AM, the Director of Nursing (DON) was asked if resident representative were notified when new medications were ordered or discontinued, she stated the resident representative should be notified. On 6/10/2021 at 3:30 PM Nurse #8 and Nurse #5 were interviewed together and stated when their residents got new orders for medications, they notified the family, and documented it in the chart. These nurses also stated when a medication is discontinued, they notify the family also. The facility Administrator, on 6/11/2021 at 1:30 PM, was asked his expectation for notification of resident representatives when medications are started or discontinued. The Administrator stated, "I would expect them to be notified."	F 580	process will be analyzed for patterns and trends and reported to Quality Assurance Performance (QAPI) committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585		7/16/21

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reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,

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Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility

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F 585	Continued From page 22 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to make prompt efforts to resolve grievances for 1 (Resident #35) of 1 resident reviewed for grievances. Findings included: Record review revealed Resident #35 was readmitted on 5/5/2021. The annual Minimum Data Set dated 2/12/2021 indicated Resident #35 was cognitively impaired and required assistance for his activities of daily living. Facility policy titled "Grievances" dated October 2017 stated the appropriate designee will investigate the allegations and report findings in a written report to the Executive Director within 72 hours. The resident, or the person filing the grievance, will be informed of the investigations findings and the actions to correct any identified problem within five business days. Facility grievance forms indicated Resident #35's family member filed a written grievance on 11/11/2020. The form indicated a copy was left in the Director of Nursing's office and in the	F 585	F585 1. Facility failed to make prompt efforts to resolve grievances for resident #35. Resident #35 grievance was resolved on 7/7/2021. 2. An audit was conducted by the Administrator of grievances over the last 30 days to ensure grievances were brought to resolution. This audit will be completed by 7/9/2021. 3. Regional Director of Operations educated Administrator and Director of Social Services on grievance process and expectations for completion and resolution. This education was provided on 7/2/2021. Administrator will audit grievance log weekly x 12 weeks to ensure that grievances were brought to resolution. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) by the	

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 585	Continued From page 23 Administrator's office. The sections of the form labeled "documentation of center follow-up" and "resolution of grievance/concern" were blank. The grievance form stated Resident #35's family member was informed Resident #35 had new skin breakdown. Resident #35's assigned nurse did not return multiple phone calls to Resident #35's family member with details of the skin breakdown. Facility grievance forms indicated Resident #35's family member filed a written grievance on 12/7/2020. The form indicated a copy was left in the Director of Nursing's office and in the Administrator's office. The sections of the form labeled "documentation of center follow-up" and "resolution of grievance/concern" were blank. The grievance voiced concerns during a window visit, Resident #35 almost fell on his floor and the nurse aide assigned was at the nurse's station on his phone. There was also a concern Resident #35 had unwashed feet when taken to the hospital. An interview was conducted on 6/9/2021 at 2:50 PM with Resident #35's family member revealed she did not remember the grievances being addressed by the facility. During the interview, Resident #35's family member stated she was embarrassed by the way Resident #35's feet looked at the hospital. An interview was conducted with the Director of Nursing (DON) on 6/9/2021 at 10:09 AM revealed she had not seen either of these two grievances before today. The DON further stated the grievance forms when completed had a resolution written on the form and were signed by staff. The grievances dated 11/11/2020 and	F 585	Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 585	Continued From page 24 12/7/2020 submitted by Resident #35's family member appeared not to have been investigated due to the form not being completed. An interview was conducted with the Administrator on 6/9/2021 at 10:15 AM. It revealed the grievances submitted by Resident #35's family member dated 11/11/2021 and 12/7/2020 were incomplete. The Administrator stated had the grievance been investigated the resolution of grievance section on the form would be completed by staff. During the interview the Administrator further stated he was unsure why the grievances were not addressed.	F 585		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		7/16/21

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F 636	Continued From page 25 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 636	F636	

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F 636	Continued From page 26 facility failed to complete a comprehensive Minimum Data Set (MDS) within the required timeframe for 2 of 36 residents whose MDS assessments were reviewed (Resident #347 and Resident #93). The findings included: 1. Resident #347 was admitted to the facility on 4/26/21. Her cumulative diagnoses included osteoporosis and anemia. Resident #347's admission Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 5/3/21. Upon review, the MDS section on Assessment Administration was not signed or dated by a Registered Nurse (RN) Assessment Coordinator verifying the assessment was completed. An interview was conducted on 6/8/21 at 3:58 PM with MDS Nurse #1. Upon request, the nurse reviewed Resident #347's admission MDS dated 5/3/21 and reported this assessment had not yet been submitted or transmitted. An interview was conducted on 6/9/21 at 8:57 AM with the facility's Director of Nursing (DON). During the interview, Resident #347's admission MDS dated 5/3/21 was discussed. The DON reported an admission MDS assessment needed to be signed and dated as completed within 14 days of the resident's admission to the facility. The DON confirmed this MDS assessment was not completed within the required timeframe. 2. Resident #93 was admitted to the facility on 4/30/21. His cumulative diagnoses included hemiparesis (a mild or partial weakness or loss of	F 636	1.Facility failed to complete a comprehensive Minimum Data Set (MDS) within the required timeframe on residents #347 and #93. Resident #347 MDS was completed on 6/8/21. Resident #93 MDS was completed on 5/25/21. 2.All current residents MDS will be reviewed Regional MDS Consultant by 7/9/2021 to ensure MDS was completed within the required timeframe. 3.Regional MDS Consultant will educate MDS nurses on completing the comprehensive MDS within the required timeframe. This education will be completed by 7/9/2021. Director of Nursing will audit 5 comprehensive MDS weekly to ensure MDS is completed within the required timeframe. The audit will be conducted weekly x 12 weeks. Administrator will review the results of the weekly audit to ensure comprehensive MDS are completed within the required timeframe. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 636	Continued From page 27 strength on one side of the body) / hemiplegia (a severe or complete loss of strength or paralysis on one side of the body). Resident #93's admission Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 5/6/21. Upon review, the MDS section on Assessment Administration was signed and dated on 5/25/21 by a Registered Nurse (RN) Assessment Coordinator verifying the assessment was completed. An interview was conducted on 6/8/21 at 3:58 PM with MDS Nurse #1. Upon request, the nurse reviewed Resident #93's admission MDS dated 5/6/21. MDS Nurse #1 confirmed the section on Assessment Administration was signed and dated as being completed on 5/25/21. An interview was conducted on 6/9/21 at 8:57 AM with the facility's Director of Nursing (DON). During the interview, Resident #93's admission MDS dated 5/9/21 was discussed. The DON reviewed the MDS assessment for this resident. When asked if the MDS had been completed within the required timeframe, she stated, "No." The DON reported an admission MDS assessment needed to be signed and dated as completed within 14 days of the resident's admission to the facility.	F 636	5.Person Responsible: Administrator	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 637		7/16/21

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F 637	Continued From page 28 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment within 14 days of being admitted to Hospice for 1 of 1 resident reviewed for Hospice (Resident #44). The findings included: Resident #44 was admitted to the facility on 3/29/21 with a diagnosis of hepatic failure and Type 2 Diabetes Mellitus. The Admission Minimum Data Set (MDS) dated 4/5/21 revealed Resident #44 was cognitively intact. A physician order was dated 5/20/21 to admit Resident #44 to Hospice services. A MDS Significant Change in Status Assessment dated 6/1/21 was observed as not completed or signed by the registered nurse. An interview with the Director of Nursing (DON) on 6/10/21 at 5:00 PM stated the MDS for Resident #44 was late. She stated the MDS nurse was new and the facility did not hire anyone immediately to replace her when she left her	F 637	F637 1. Facility failed to complete significant change within the required timeframe residents on resident #44. Resident #44 significant change was completed on 6/15/21. 2. All current residents Minimum Data Set (MDS) assessment will be reviewed Regional MDS Consultant by 7/9/2021 to ensure MDS was completed within the required timeframe. 3. Regional MDS Coordinator will educate MDS nurses on completing the significant change MDS within the required timeframe. This education will be completed by 7/9/2021. MDS Coordinator will audit 5 significant change MDS weekly to ensure MDS is completed within the required timeframe. This audit will be conducted weekly x 12 weeks. Administrator will review the results of the weekly audit to ensure significant change MDS are completed within the required	

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F 637	Continued From page 29 position as the MDS nurse to become the Director of Nursing.	F 637	timeframe. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI (Quality Assurance Performance Improvement) committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (ARD, designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time) for 5 of 11 residents reviewed (Residents #31, #3, #5, #4, and #8). The findings included: 1. Resident #31 was admitted to the facility on 2/20/21 with a diagnosis of dementia and muscle	F 638	F638 1. Facility failed to complete quarterly review assessment within the required timeframe residents on residents #31, #3, #5, #4, and #8. Resident #31 quarterly review assessment was completed on 6/27/21. Resident #3 quarterly review assessment was completed on 6/12/21. Resident #5 quarterly review assessment was completed on 6/12/21. Resident #4 quarterly review will be completed by 7/9/2021. Resident #8 quarterly review assessment was completed on 6/12/21.	7/16/21

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F 638	Continued From page 30 weakness. A review of Resident #31's Minimum Data Set (MDS) revealed a completed comprehensive admission MDS assessment dated 2/20/21. The next MDS assessment had an ARD of 5/23/21 and was observed as not signed by a registered nurse and remained open. An interview with the Director of Nursing (DON) on 6/10/21 at 5:00 PM stated the MDS for Resident #31 was late. She stated the MDS nurse was new and the facility did not hire anyone immediately to replace her when she left her position as the MDS nurse to become the DON. 2. Resident #3 was admitted to the facility on 10/15/18. Her cumulative diagnoses included diabetes and hypertension. A review of Resident #3's Minimum Data Set (MDS) assessments revealed her most recent (completed) assessment was a quarterly MDS with an Assessment Reference Date (ARD) of 1/27/21. The next quarterly MDS assessment was scheduled with an ARD of 4/27/21. However, Resident #3's electronic medical record indicated her 4/27/21 quarterly MDS was incomplete with a notation which read, "Change Reason for Assessment." An interview was conducted on 6/11/21 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, Resident #3's quarterly MDS assessment dated 4/27/21 was reviewed and the DON confirmed, "It's late." The DON reported 4 sections on the MDS were not yet completed. These included the sections pertaining to the resident's Functional Abilities and Goals, Bladder and Bowel, Health Conditions, and Special	F 638	2. All current residents most recent Minimum Data Set (MDS) assessment will be reviewed by Regional MDS Consultant by 7/9/2021 to ensure MDS was completed within the required timeframe. 3. Regional MDS Coordinator will educate MDS nurses on completing the quarterly MDS within the required timeframe. This education will be completed by 7/9/2021. MDS Coordinator will audit 5 quarterly MDS to ensure MDS is completed within the required timeframe. This audit will be completed x 12 weeks. Administrator will review the results of the weekly audit to ensure quarterly MDS are completed within the required timeframe. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) committee by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 638	Continued From page 31	F 638		

Treatments and Programs. The DON also noted the MDS section on Assessment Administration was not signed or dated by a Registered Nurse (RN) Assessment Coordinator to verify completion of the assessment.
3. Review of records revealed Resident #5 was admitted 11/24/2018 with diagnoses including Diabetes Mellitus, Dementia and Depression.

A review of Resident #5's Minimum Data Set (MDS) revealed an Annual assessment on 10/17/2020, a Quarterly assessment on 1/16/2021 and a Quarterly assessment on 1/27/21, but no assessments were noted after those.

On 6/10/2021 at 11:00 AM the MDS coordinator stated she did not know why another assessment had not been completed.

On 6/10/2021 at 11:15 AM, The Director of Nursing (DON) was interviewed and stated the Quarterly assessment for 4/27/2021 was not completed. The DON stated eight sections were finished but it has not been transmitted because it is not complete.
4. Resident #4 was admitted on 07/19/2021 with diagnoses which included and hypertension, chronic kidney disease and dementia.

A review of Resident #4's Minimum Data Set (MDS) assessments revealed her most recent (complete) assessment was a quarterly MDS with an Assessment Reference Date (ARD) of 01/26/2021. The next quarterly MDS assessment was scheduled with an ARD of 04/27/2021. Resident #4's electronic medical record indicated her 04/27/2021 quarterly assessment was not signed or dated by a Registered Nurse and had a

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F 638	Continued From page 32	F 638		

status of "open."

An interview was conducted on 06/10/2021 at 1:01 pm with MDS Nurse #1 and revealed the nurse reviewed Resident #4's quarterly MDS dated 04/27/2021 and reported this assessment had not yet been submitted or transmitted.

An interview with the Director of Nursing (DON) on 06/11/2021 at 11:43 am revealed Resident #4's quarterly MDS assessment was late. She stated the MDS nurse was new in her role and the facility did not hire anyone immediately to replace her when the position became open. The DON stated she was the MDS nurse prior to taking the DON position in March of 2021. She stated MDS assessments should be completed within the required timeframe for all residents.

5. Resident #8 was admitted to the facility on 01/26/2017 with diagnoses which included Type II diabetes, muscle weakness, unspecified dementia.

A review of Resident #8's Minimum Data Set (MDS) assessments revealed her most recent (complete) assessment was a quarterly MDS with an Assessment Reference Date (ARD) of 01/29/2021. The next quarterly MDS assessment was scheduled with an ARD of 04/29/2021. Resident #8's electronic medical record indicated her 04/22/2021 quarterly assessment was not signed or dated by a Registered Nurse and had a status of "open."

An interview was conducted on 06/10/2021 at 1:01 pm with MDS Nurse #1. Upon request, the nurse reviewed Resident #8 ' s quarterly MDS dated 04/29/2021 and reported this assessment

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F 638	Continued From page 33 had not yet been submitted or transmitted. An interview with the Director of Nursing (DON) on 06/11/2021 at 11:43 am revealed Resident #8's quarterly MDS assessment was late. She stated the MDS nurse was new in her role and the facility did not hire anyone immediately to replace her when the position became open. The DON stated she was the MDS nurse prior to taking the DON position in March of 2021. She stated MDS assessments should be completed within the required timeframe for all residents.	F 638		
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 code the Minimum Data Set (MDS) assessment accurately in the areas of mental health illness (Resident #247), diagnoses (Resident #247) and medications (#247, #77) for 2 of 21 sampled residents reviewed for MDS accuracy. (Residents #247, #77) Findings Included: 1. A Determination Notification Letter for a Preadmission Screening and Resident Review (PASARR, an evaluation that determines if the mental illness needs of the individual can be met in a Nursing Facility or if the individual requires Specialized Services) Level II dated 5/6/2021 revealed Resident #247 was approved for placement in the facility for thirty days.	F 641	F641 1. The facility failed to accurately code resident #247 in the areas of mental health illness and resident #77 in the areas of medication. Resident #247 MDS was modified on 7/2/2021 Resident #77 MDS was modified on 7/2/2021. 2. MDS will review residents that currently have a mental health illness diagnosis and residents that are currently on an antipsychotic medication to ensure MDS are accurate. If discrepancies are found MDS are to modify assessments. This review will be completed by 7/9/2021. 3. Regional MDS Consultant will educate	7/16/21

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F 641	Continued From page 34 Resident #247 was admitted to the facility on 5/11/2021. Her diagnoses included anxiety disorder, depressive disorder, traumatic brain injury, and attention deficit hyperactivity disorder (ADHD) and malignant neoplasm. A review of the physician orders revealed on 5/11/2021 Resident #247 was receiving Enoxaparin (anticoagulant), Buspirone (antianxiety), Lorazepam (antianxiety), Trazodone (antidepressant), and amphetamine/dextroamphetamine (stimulant) medications. The baseline care plan dated 5/11/2021 revealed Resident #247 was receiving psychotropic medications and listed Lorazepam, an antianxiety medication. A review of the physician progress notes dated 5/13/2021 revealed the following diagnoses for Resident #247: ADHD, anxiety disorder, major depressive disorder, history of traumatic brain injury and malignant neoplasm. The admission Minimum Data Set (MDS) assessment dated 5/17/2021 revealed the Resident #247 was not currently considered by the state a Level II Preadmission Screening and Resident Review (PASARR) and had no serious mental illness (MR) or intellectual disabling (ID) conditions. The MDS listed no diagnoses for Resident #247 and recorded her receiving no medications. On 6/8/2021 at 2:58 p.m. in an interview with the Director of Nursing, she stated the MDS nurse conducted and documented the first	F 641	MDS nurses on completed MDS assessment accurately when a resident has a mental health illness diagnosis and antipsychotic medications. This education will be completed by 7/7/2021. Director of Nursing will audit 5 significant change MDS on to ensure assessment accurately when a resident has a mental health illness diagnosis and antipsychotic medications. This audit will be conducted weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Administrator.	

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comprehensive assessment on the MDS that included the PASARR screening, diagnoses, and medications.

On 6/9/2021 at 4:07 p.m. in an interview with the MDS Nurse, she stated the reason diagnoses were not viewable on the MDS was because an icon to view the diagnoses had not been clicked by the previous MDS nurse. She verified no diagnoses or medications were listed on the MDS but stated anticoagulants and antipsychotic medications needed to be checked based on the medications Resident #247 was ordered and received.

On 6/11/2021 at 9:40am in a follow-up interview with the MDS nurse, she stated based on Resident #247's diagnoses, the serious mental illness box needed to be checked.

On 6/11/2021 at 9:52 a.m. in an interview with the Administrator, he stated the MDS assessment needed to be completed accurately and stated until recently the facility did not have an MDS nurse and depended on a traveling MDS nurse for the completion of MDS assessments.

2. Resident #77 was admitted to the facility on 1/22/18 with re-entry from a hospital on 8/11/19. Her cumulative diagnoses included non-Alzheimer's dementia, anxiety disorder,

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depression, and unspecified psychosis not due to a substance or known physiological condition.

A review of Resident #77's physician orders included a medication order dated 3/8/21 for 50 milligrams (mg) quetiapine (an antipsychotic medication) to be given as one tablet by mouth twice daily for paranoid delusions and hallucinations.

Resident #77's March 2021 and April 2021 Medication Administration Records (MARs) were reviewed. Documentation on the MARs revealed Resident #77 received quetiapine each day as ordered (including the dates of 3/31/21 through 4/6/21).

A review of Resident #77's quarterly Minimum Data Set (MDS) assessment dated 4/6/21 was conducted. The MDS assessment indicated this resident received an antipsychotic medication on 7 out of 7 days during the look back period (3/31/21 - 4/6/21). However, the Antipsychotic Medication Review was coded to indicate the resident did not receive any antipsychotic medications during this period.

An interview was conducted on 6/9/21 at 2:40 PM with MDS Nurse #1. During the interview, MDS Nurse #1 reviewed Resident #77's quarterly MDS assessment dated 4/6/21. The nurse confirmed there was a discrepancy with the coding of the resident's antipsychotic medication. Upon review of Resident #77's March 2021 and April 2021 MARs, MDS Nurse #1 reported the resident did receive an antipsychotic medication on each of the 7 days during the 7-day look back period. She stated the information in the Antipsychotic Medication Review was a coding error.

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F 641	Continued From page 37 An interview was conducted on 6/11/21 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the coding error for the antipsychotic medication on Resident #77's quarterly MDS assessment was discussed. The DON reported she would expect a resident's MDS assessment to be coded accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a Preadmission Screening and Resident Review (PASARR) assessment before the expiration date of the PASARR Level II for 1 of 3 sampled residents (Resident #247) for PASARR.	F 644	F644 1. Facility failed to submit a Preadmission Screening and Resident Review (PASARR) assessment before the expiration date of the PASARR Level II for	7/16/21

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F 644	Continued From page 38 Findings Included: Resident #247 was admitted on 5/11/2021, and her diagnoses included Attention Deficit Hyperactivity disorder (ADHD), anxiety disorder and traumatic brain injury. Resident #247's baseline care plan dated 5/11/2021 revealed she was receiving psychotropic medications. A review for the physician progress notes dated 5/13/2021 revealed Resident #247 had a history of a traumatic brain injury, an anxiety disorder, a major depressive disorder and ADHD. Resident #247's comprehensive care plan dated 6/7/2021 did not address a focus on psychotropic medications or any psychological diagnoses. On 6/7/2021 at 8:50am, a PASARR Level II Determination Notification Letter revealed Resident #247's PASARR Level II expired on 6/5/2021 and limited her placement in the nursing facility for no more than 30 days. The letter also stated further approval and screening must be obtained if Resident #247's stay in the facility was expected to be beyond the end date. On 6/7/2021 at 10:11am in an interview with the Admission Coordinator, she stated she did not have access to the required information for PASARR Level II applications, and the social worker processed the PASARR Level II applications. She stated Resident #247's PASARR Level II expired on 6/5/2021. On 6/7/2021 at 11:10am, the North Carolina	F 644	Resident #247. Resident #247 PASARR level II was submitted on 6/7/2021, approved on 6/10/2021 and expires on 8/9/2021. 2. A PASARR audit will be conducted for all current residents to ensure PASARRs are not expired and up to date. This audit will be completed by 7/9/2021. 3. Social Worker was educated by Administrator on expectation that PASARRs are not to expire and remain up to date. This education will be completed by 7/7/2021. Social Worker will audit all current residents PASARR to ensure they are not expired and remain up to date weekly x 12 weeks. Administrator will review weekly PASARR audit to ensure PASARRs aren□t expired and remain up to date. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 644	Continued From page 39 Medicaid Uniform Screening Tool (NC MUST) form revealed PASARR information was submitted by the social worker on 6/7/2021a at 9:54am for review. On 6/8/2021 at 2:25pm in an interview with the social worker, she stated she usually submitted information for PASARR Level II renewals five days prior to expiration. She stated Resident #247 PASARR Level II expired on 6/5/2021, and she submitted the information to NC MUST on 6/7/2021. She stated she was out of the office the week prior to the expiration, and she was the only person that tracked and completed the applications prior to expirations. On 6/8/2021 at 2:58pm in an interview with the Director of Nursing, she stated the social worker kept track of expirations of PASARR Level IIs and conducted the reapplication process for PASARR Level II. She further stated in the absence of the Social Worker, the Admission Coordinator continued the application process for PASARR Level II. On 6/8/2021 at 4:37pm in an interview with the Administrator, he stated the social worker and admission coordinator needed to complete PASARR evaluations and update PASARR Level II prior to expirations. Based on record review and staff interviews, the facility failed to submit PASARR assessments before the expiration date of the PASARR II for 1 of 3 sampled residents (Resident #247) for PASARR.	F 644		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the	F 646		7/16/21

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F 646	Continued From page 40 state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the state mental health authority of a significant change in status for a resident diagnosed with Schizophrenia and Bipolar for 1 of 3 residents (Resident #58) reviewed for Preadmission Screening and Resident Review (PASARR). Findings Included: Resident #58 was admitted on 10/1/2020. Her diagnoses included Schizophrenia, Bipolar and anxiety. A Level I PASARR determination letter dated 11/18/2018 was observed for Resident #58. No Level II PASARR determination letter was observed in the resident ' s record or in the facility's PASARR book. A review of the physician progress notes dated 10/2/2020 revealed Resident #58 had a past medical history of Schizophrenia, Bipolar and Involuntary Commitment (IVC) and was presently stable with current home medication regimen. A review of the physician orders dated 10/6/2020 revealed Resident #58 was receiving Olanzapine (antipsychotic medication) 10 milligrams (mg) every day and 15mg at bedtime for Schizophrenia, Quetiapine (antipsychotic medication) 25mg at bedtime for Bipolar and	F 646	F646 1. Facility failed to notify the state mental health authority of a significant change in status for a resident diagnosed with Schizophrenia and Bipolar for Resident #58 reviewed for Preadmission Screening and Resident Review (PASARR). Mental health authority was notified of significant change in status of Resident #58 on 6/8/2021. Level II PASARR issued on 6/21/2021 for Resident #58. 2. An audit of current residents was conducted to ensure that the state mental health authority was notified of a significant change in status in a mental health diagnosis. This audit will be completed by 7/9/2021. 3. Social Worker was educated by Administrator on expectation that the state mental health authority be notified of a significant change in status in a mental health diagnosis. This education completed by 7/7/2021. Social Worker will conduct an audit to ensure that the state mental health authority was notified of a significant change in status in a mental health	

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F 646	Continued From page 41 Lorazepam (antianxiety medication) 1mg twice a day for anxiety. The admission Minimum Data Set (MDS) assessment dated 10/8/2020 revealed Resident #58 had moderate cognitive impairment with no psychotic behaviors exhibited. The MDS further revealed she had received antipsychotic medications and listed Schizophrenia, Bipolar and anxiety as diagnoses. Resident #58's care plan dated 10/12/2020 revealed a focus for Schizophrenia, Bipolar and Anxiety. Interventions included the administration of medications, monitoring for medication side effects, mood, behaviors, hallucinations, delusions and irritability. The updated care plan dated 4/18/2021 revealed Resident #58 was at risk for side effects with the use of antipsychotic and antianxiety medication use, and interventions included monitoring patterns of behaviors and reporting changes. The care plan dated 4/18/2021 further included Resident #58 was resistant to and refused daily care. Interventions included assessing the effectiveness of antianxiety and antipsychotic medication therapy, administering medications as ordered and monitoring the side effects of psychoactive medications. Nursing documentation dated 3/25/2021 revealed a change in Resident #58's behavior. She began singing and yelling out loud and progressed to yelling in an aggressive and threatening manner and refusing medications and meals. On 4/1/2021 when Resident #58 was sent to the hospital, her behaviors included verbally threatening bodily harm to kill staff and burning down the building.	F 646	diagnosis. Social Worker will audit 20 residents per week x 12 weeks. Administrator will review the results of the audit to ensure that the state mental health authority was notified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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A review of the hospital discharge summary dated 4/9/2021 revealed Resident #58 was involuntary commitment because of aggressive behavior in the facility and was awaiting admission to a psychiatric hospital.

On 4/12/2021, Resident #58 was re-admitted to the facility.

A review of the psychiatric physician notes dated 4/14/2021 revealed Resident #58 was admitted to the hospital for aggressive behavior from 4/1/2021 to 4/12/202, and her antipsychotic medications had been increased. The physician documented Resident #58 was irritable and paranoid, but recorded no disruptive behaviors had been reported since returning to the facility.

On 6/8/2021 at 10:11 a.m. in an interview with the Admission Coordinator, she stated Resident #58 was not admitted with a Level II PASARR.

On 6/8/2021 at 2:13 p.m. in an interview with the Social Worker, she stated she did not know why Resident #58 had a Level I PASARR and stated she needed to be a Level II PASARR. She further stated Resident #58 had been out of the facility for an extended period with exacerbation of the mental disease process and notification to the mental health authority should had been done. She stated, "I missed it."

On 6/8/2021 at 3:05 p.m. in an interview with the Director of Nursing, she stated Resident #58 had a change in her behavior and was exhibiting aggressive behaviors, communicating threats and being paranoid prior to sending to the hospital. She further stated with the diagnose of

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F 646	Continued From page 43 Schizophrenia and the change in behavior, the social worker should had conducted a Level II PASARR review. On 6/8/2021 at 4:37 p.m. in an interview with the Administrator, he stated the social worker and admission coordinator needed to keep PASARR evaluations updated at all times.	F 646		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		7/16/21

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F 656	Continued From page 44 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 5 residents(Resident #247) reviewed for unnecessary medications that received daily doses of psychotropic and anticoagulant medications and for 1 of 1 resident (Resident #62) reviewed for limited range of motion with the use of a left handed splint. Findings Included: 1. Resident #247 was admitted to the facility on 5/11/2021, and her diagnoses included a traumatic brain injury, attention deficit hyperanxiety disorder (ADHD), anxiety disorder and a malignant neoplasm. A review of the baseline care plan dated 5/11/2021 listed Resident #247 receiving Lorazepam, an antianxiety medication, twice a day. A review of the physician ' s orders dated 5/11/2021 revealed Resident #247 was ordered	F 656	F656 1. Facility failed to develop a comprehensive care plan for Resident Care Plan for Resident #247 and #62. Comprehensive care plan was completed for Resident #247 on 7/2/2021. Comprehensive care plan was completed for Resident #62 on 5/13/2021. 2. All current residents MDS will be reviewed by Regional MDS Consultant to ensure comprehensive care plan was completed. This audit will be completed by 7/9/2021. 3. Regional MDS Consultant will educate MDS nurses on completing comprehensive care plans on or before the 21st day of stay for the resident and updating the care plan during the quarterly assessment. This education will be completed by 7/7/2021.	

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F 656	Continued From page 45 Enoxaparin, an anticoagulant medication, 40 milligrams (mg) daily and Trazadone, an antianxiety medication, 50 mg at night. The physician orders further revealed during the month of May 2021 the following psychotropic medications had been ordered and discontinued for Resident #247: Buspirone, an antidepressant, Lorazepam, an antianxiety, and Amphetamine/Dextroamphetamine, a stimulant. The admission Minimum Data Set (MDS) assessment dated 5/17/2021 revealed Resident #247 was cognitively intact and required assistance with activities of daily living. No diagnoses or medications were listed on the MDS. A review of the Medication Administration Record (MAR) for May 2021 and June 2021 revealed Resident #247 was administered the medications, Enoxaparin and Trazadone, daily. A comprehensive care plan dated started on 6/7/2021 revealed Resident #247 was care planned for nutrition and falls only. There was no care plan for psychotropic and anticoagulant medication use, behaviors or bleeding. On 6/8/2021 at 7:30 p.m. in an interview with Nurse #12, she stated the admission nurse completed a baseline care plan, and the comprehensive care plan was conducted by the MDS nurse. On 6/9/2021 at 4:07 p.m. in an interview with the MDS nurse, she stated comprehensive care plans were to be completed within twenty-one days from when the resident was admitted.	F 656	Director of Nursing will audit 5 residents per week to ensure completion of comprehensive care plans. This audit will be completed weekly x 12 weeks. Administrator will review the results of the weekly audit to ensure the completion of comprehensive care plans. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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On 6/10/2021 at 3:49 p.m. in an interview with the Director of Nursing, she stated Resident #247 comprehensive care plan should have included a care plan for bleeding, mood, behavior and medications.

2. Resident #62 was admitted on 9/15/2020. Her diagnoses included cerebral vascular accident and hemiplegia.

The re-admission Minimum Data Set (MDS) assessment dated 9/22/2020 revealed Resident #62 was cognitively intact and had impairments to one side on the upper and lower part of the body. The MDS further revealed Resident #62 required extensive assistance with all activities of daily living except eating and occupational therapy had started on 9/16/2020. The quarterly MDS assessment dated 4/3/2021 revealed Resident #62 was not receiving therapy services.

The occupational therapy discharge summary dated 3/19/2021 revealed a splinting schedule for the left wrist and hand had been implemented, and nurse aides were trained to apply the left upper extremity(LUE) hand splint during morning activities of daily living.

Resident #62 ' s care plan dated 5/13/2021 revealed she required extensive to total assistance with activities or daily living, and interventions included occupational therapy for evaluation. The care plan did not include application of the LUE hand splint.

On 6/9/2021 at 4:07 p.m. in an interview with the MDS nurse, she stated comprehensive care plans were completed within twenty-one days

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F 656	Continued From page 47 from when the resident was admitted and updated if there was a significant change and quarterly. On 6/10/2021 at 3:57 p.m. in an interview with the Director of Nursing (DON), she stated the use of splints needed to be on the care plan. On 6/10/2021 at 4:40 p.m. in an interview with the Director of Therapy, she stated therapy completed a form to communicated orders for splints to the MDS nurse and the DON. On 6/11/2021 at 8:28 a.m. in an interview with the Director of Therapy, she was unable locate a copy of the form used to communicated orders to the MDS nurse and the DON. She stated the department started using the form in late March 2021 and prior to the use of the form, therapy communicated updates on the residents during the morning clinical meetings. On 6/11/2021 at 9:52 a.m. in an interview with the Administrator, he stated the leadership team provided information in the Interdisciplinary Team (IDT) meetings, and resident ' s care plan were to be completed and updated as required.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		7/16/21

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F 657	Continued From page 48 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to conduct care plan meetings within the required timeframe for 2 of 2 residents reviewed, (Resident # 9 and Resident #70). The findings include: 1. Resident #9 was admitted to the facility on 10/05/2020 with a diagnosis of hypertension, generalized weakness and dementia without behavioral disturbance. A review of the quarterly Minimum Data Set (MDS) dated 04/01/2021 revealed Resident #9 was cognitively intact, required supervision with bed mobility, transfer, dressing, eating, toileting and personal hygiene.	F 657	F657 1. Facility failed to conduct care plan meetings within the required timeframe for Resident #9 and Resident #70. Care plan meetings for Resident #9 and Resident #70 will be completed by 7/9/2021. 2. An audit was conducted for current facility residents to ensure care plan meetings were conducted within the required timeframe. This audit will be completed by 7/9/2021. 3. Social Worker will be educated by the Administrator regarding conducting care plan meetings within the required timeframe. This education will be	

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F 657	Continued From page 49 A review of Resident #9's care plan updated 06/06/2021 revealed Resident #9. A review of Resident #9's care plan conference notes revealed an Interdisciplinary Team (IT) meeting was held on 02/19/2021. The care plan conference notes also revealed the next care plan IT meeting was due to be held on or before on 5/12/2021. An interview with Resident #9 on 06/08/2021 revealed she had not had a recent care plan meeting with anyone at the facility. She stated the last meeting she knew of was in February 2021. An interview with the Social Worker on 06/09/21 at 04:19 PM revealed there had not been another IT meeting for Resident #9 since 02/19/2021. She stated they are required to meet at least every 90 days. An interview with the DON on 06/09/21 04:31 revealed the facility should conduct IT meetings for all residents at least every 90 days or sooner if needed. An interview with the Administrator on 06/11/2021 at 9:36 am revealed care plan meetings should be held by the IT for all residents as medical changes occur or a minimum of every 90 days. 2. Review of the medical record revealed Resident #70 was admitted 6/13/2020 with diagnoses including dementia, depression, coronary artery disease and Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 4/6/2021 noted Resident #70 was severely	F 657	completed by 7/7/2021. Social worker will audit 5 residents per week to ensure that care plan meetings are conducted within the required timeframes x 12 weeks. Administrator will review the results of the weekly audit to ensure that care plan meetings are conducted within the required timeframes. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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impaired for cognition and needed limited to extensive assistance for all daily care with the help of one to two persons. The Care Area Assessment focused on dementia, communication, and nutrition.

On 6/6/2021 at 1:00 PM, the family member of Resident #70 was interviewed and stated the family had requested a care plan meeting on several occasions. The family member stated no one from the facility would call back. The family member stated a number was found for the corporation that owned the facility, that number was called, and a care plan meeting was conducted the following day. This was October of 2020. The family member stated there had been no other care plan meeting conducted since October of 2020.

Review of progress notes revealed no documentation of a care plan or Interdisciplinary Team meeting.
On 6/10/2021 at 11:49 AM, the facility Social Worker stated sometimes the admission care plan meetings are held and are in the hard chart. The Social Worker obtained the hard chart and stated there was no care plan meeting in it. It was explained to the Social Worker there were no care plan meeting notes in the electronic health record. The Social Worker stated not to look anymore, there were no meetings. The Social Worker acknowledged care plan meetings are to be held every 90 days.

An interview with the Director of Nursing was conducted on 6/10/2021 at 12:25 PM, and she stated a care plan conference should be held on admission, and quarterly and if there is a change in condition.

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F 657	Continued From page 51 On 6/10/2021 at 12:35 PM, the facility Administrator stated his expectation was residents should have care plan meetings on time.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to provide complete daily bathing for 1 of 2 residents reviewed who required total assistance for all daily care (Resident #197). Findings included: Review of the medical record revealed Resident #197 was admitted 5/23/2019 with diagnoses including Diabetes Mellitus, End Stage Renal Disease and depression. The Annual Minimum Data Set (MDS) dated 4/6/21 indicated Resident #197 was cognitively intact and required total assistance for all daily care with the help of 1 to 2 persons. The Care Area Assessment noted a focus of Activities of Daily Living (ADLs) and this area went to care planning. The care plan dated 4/29/2020 noted Resident #197 requires assistance for eating, transfers, toileting and bathing related to amputations and	F 677	F677 1. Facility failed to provide complete daily bathing for resident #197. Resident #197 received bed bath upon notification. 2. All current residents have the potential to be affected by the alleged practice. An audit was completed by MDS Coordinator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on all Alert and Oriented residents to ask what their preferred shower and/or bath days. For the residents that are unable to express their preference, their Responsible Party and/or Power of Attorney were asked their preferred shower day and/or bath days by MDS Coordinator, DON, and ADON. This audit will be completed by 7/9/2021. Changes made to shower schedule as needed. 3. All nursing staff will be educated regarding expectations that the residents	7/16/21

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F 677	Continued From page 52 bilateral hand contractures. Interventions included: Nursing provides setup of ADL supplies, offers prompts, cues and hands-on assistance to complete tasks. Assist with perineal cleansing as needed. On 6/6/2021 at 3:20 PM, Resident #197 stated in an interview that only one Nursing Assistant (NA) would wash his private area when bathing him. Resident #197 indicated it was NA #2 and she was working that day. The Resident stated NA #2 told him she knew he had not had a complete bath because he smelled. Resident #197 stated "I was so embarrassed, because I knew it was true." Resident #197 noted NA #1 had fussed at him because he told the Director of Nursing when NA #1 had not washed him completely. Resident #197's bed bath was observed on 6/8/2021 at 10:30 AM, given by NA #2. The NA was thorough and carried on pleasant conversation with Resident #197 while she gave him a bath. NA #2 was interviewed on 6/8/2021 at 11:15 AM and stated if she was off and returned the next day, she could tell if Resident #197 had been bathed or not, because he had an odor from his private area. On 6/9/2021 at 11:45 AM, NA #1 was interviewed and stated she usually worked the middle assignment of the hall, not the end where Resident #197 was. NA #1 indicated she usually gave her residents a good bath and stated she did not know why Resident #197 said that about her. On 6/9/2021 at 12:15 PM, in an interview, the	F 677	shower/bed bath is completed on the designed day and the process if a resident refuses a shower/bed bath. Nursing staff will also educated on properly dressing the resident. Education completed by DON and/or ADON and will be complete by 7/9/2021. Nurse managers will audit the weekly shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath as scheduled per their preference. Audit will be conducted weekly x 12 weeks. Director of Nursing will review weekly audits to ensure shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath as scheduled and per their preference. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI)committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person responsible: Director of Nursing	

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F 677	Continued From page 53 Director of Nursing (DON) stated Resident #197 stated to her that NA #1 did not give him a complete bath. The DON stated she did not file a grievance, because the Administrator told her not to, that they would take care of it and just talk to the NA's. The DON stated the NAs were reeducated. On 6/10/2021 at 12:04 PM, the facility Administrator stated he expected residents to get baths daily and showers as scheduled.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner (NP), Physician and staff interview, the facility failed to complete dressing changes as ordered by the physician for 1 of 1 resident which resulted in the resident being admitted to the hospital for a wound washout and application of a wound vac, (Resident #397). The findings included: Resident #397 was admitted to the facility on 07/29/2020 with diagnoses which included diabetes mellitus, Peripheral vascular disease	F 684	F684 1. Facility failed to complete dressing changes as ordered by the physician for resident #397. Resident #397 is no longer at the facility. 2. All current residents with treatments were verified to have complete dressing changes with the correct date. This audit was completed on 6/9/2021 by nurse managers.	7/16/21

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F 684	Continued From page 54 (PVD), acquired absence of right leg above the knee, end stage renal disease, generalized weakness and dependence on renal dialysis. A review of the admission Minimum Data Set (MDS) dated 08/05/2020 revealed Resident #397 was cognitively intact and required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. Resident #397 was independent for eating. A review of Resident #397's care plan revealed an Activities of Daily Living (ADL) self-care deficit related to weakness, pain, impaired balance and right Above the Knee Amputation (AKA). Resident #397 was also care planned for skin integrity for actual alterations as evidenced by a surgical wound right AKA and was at risk for further skin breakdown/pressure ulcer development due to weakness and impaired bed mobility. Interventions included treatment to right AKA as ordered. /Resident #397 was seen by the N/ of a vascular center on 08/07/2020 for follow-up regarding a right AKA. A review of the visit summary dated 08/07/2020 reveaeld no malodor or dark drainage present and a new dressing was dated and applied to her right AKA. A review of the after-visit orders provided to the facility indicated Resident #397's right AKA incision line was to be cleaned, dry-packed and covered with a wet-to-dry dressing every day. Resident #397 was given an appointment to return to the vascular clinic on 08/10/2020. A review of the facility physician orders revealed an order was written for Resident #397 on 08/07/2020 to clean the right AKA incision line	F 684	3. Director of Nursing and/or designee will educate wound nurse and licenses nurses on completing dressing changes as ordered by physician. All Licensed nurses will be educated in orientation. Education completed by 7/9/2021. Director of Nursing, unit managers and or designee will audit 5 residents with treatments per week x 12 weeks to ensure treatments completed as ordered. Director of Nursing will review the results of the audit weekly to ensure that treatments were completed as ordered. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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daily and dry-pack the wound, then cover with a wet-to-dry dressing. The order also included the dressing could be changed twice daily if excessive drainage was noted.

A review of the Treatment Administration Record (TAR) for Resident #397 dated 08/08/2020 and 08/09/2020 revealed no staff signatures for either of these days. The TAR comment section for both 08/08/2020 and 08/09/2020 read as follows:
· "Right AKA dressing each day scheduled for 08/08/2020 was not administered."
· "Right AKA dressing each day scheduled for 08/09/2020 was not administered."

On 08/10/2021, Resident #397 returned to the vascular clinic for the scheduled appointment. A review of the NP visit summary from the vascular center revealed "dressings were not changed at the facility as ordered and the same dressing placed on 08/07/2021 was still on the resident's wound. The wound was dark and malodorous with drainage noted." The summary also indicated Resident #397 needed continuous wound care to the right AKA incision and was scheduled for an AKA wound washout with a possible wound vac placement to prevent further risk of infection. Resident #397 was sent to an Emergency Room (ER) from the vascular center and did not return to the facility.

A review of the hospital ER records dated 08/10/2020 revealed Resident #397 presented with a non-healing wound to the right AKA with brown serosanguous drainage. Resident #397 was scheduled to undergo a wound washout and placment of a wound vac on 08/11/2020 and was admitted to the hospital on the evening of 08/10/2020.

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A review of the hospital records for visit dated 08/11/2020 revealed Resident #397 underwent right AKA washout and a wound vac was placed on 08/11/2020. Resident #397 was discharged to home with family on 08/13/2020 and was given follow up instructions and return appointment.

A review of the hospital discharge summary dated 08/13/2020 revealed Resident #397's care involved complexity due to the comorbidities listed in the history and physical.

A review of the facility's nursing assignment sheets for 08/08/2020 and 08/09/2020 revealed the nurses assigned to Resident #397 for each of these days were unavailable for interview.

A review of Nurse #11's progress note dated 08/11/2020 labeled as "late entry," revealed Nurse #11 received a call from the vascular clinic regarding Resident #397 to inform the facility the resident was being sent to the ER for surgery on her right AKA.

An interview with Nurse #11 on 06/08/2021 at 11:17 am revealed she remembered Resident #397 but didn't remember the details of the phone conversation from the vascular office as to why the resident had to go to the ER on 08/10/2020. She stated she had been off on both 08/08/2020 and 08/09/2020 and returned to work on 08/10/2020.

An attempt was made to contact the resident for interview, but the phone number in the medical record for Resident #347 had been disconnected.

In a phone interview with the vascular center NP

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on 06/07/2021 at 1:46 pm, the NP stated she provided care to Resident #397 for her right AKA on Friday, 08/07/2020, and ordered wet to dry dressing changes daily and as needed. During the visit, Resident #397 expressed concern that the facility would not change her dressing daily because she felt they may be short staffed. The NP stated she made Resident #397 an appointment to return to the vascular center on Monday, 08/10/2020 as a follow up just in case the facility did not change her dressing. The NP indicated Resident #397 returned to the vascular appointment on 08/10/2020 with the same dressing the NP had applied on Friday, 08/07/2020. She noted Resident #397 was scheduled for a debridement and possible wound vac placement for the next day, 08/11/2020 at a hospital. Resident #397 was sent to the ER from the vascular center. The NP stated Resident #397 had many comorbidities that could hinder the healing process of the right AKA and the NP could not say the lack of dressing changes caused the resident to need further treatment to her wound.

An interview with a Corporate Nurse Consultant on 06/08/2021 at 10:53 am revealed there was a grievance filed by the vascular center on 08/07/2020 about Resident #397's dressing not being changed per the physician order. The Nurse Consultant stated she logged the grievance and further stated Resident #397 was discharged on 08/10/2020. The Consultant indicated she had no opportunity to interview the resident regarding the grievance. The Consultant stated the nursing staff did not change the resident's dressing on the dates of 08/08/2020 and 08/09/2020, and she had nothing to add but the nurses "just didn't change the dressing as

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F 684	Continued From page 58 ordered. The interview with the Director of Nursing on 06/11/2021 at 11:43 pm revealed the nursing staff should follow physician orders and change all dressings as ordered. An interview with a physician on 06/11/2021 at 2:45 pm revealed he was aware Resident #397 did not receive dressing changes to her right AKA on the dates of 08/08/2020 and 08/09/2020. He stated the resident had complicated diagnoses that contributed to the inability of her body being able to heal during the stress of a right AKA. He stated Resident #397's wound debridement was unavoidable.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		7/16/21

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F 688	Continued From page 59 by: Based on record review, observations and resident and staff interviews, the facility failed to obtain a physician's order to communicate the application of the left hand splint as recommended by occupational therapy for 1 of 1 residents reviewed. (Resident #62) Findings included: Resident #62 was admitted to the facility on 9/15/2020, and her diagnoses included cerebral vascular accident (stroke) and hemiplegia. The admission Minimum Data Set (MDS) assessment dated 9/22/2021 revealed Resident #62 was cognitively intact and one upper and lower side of the body was impaired. The MDS further revealed Resident #62 required extensive assistance with all activities of daily living (ADLs) except eating. A review of the occupational therapy discharge notes dated 3/19/2021 revealed Resident #62 was provided a hand splint, and a splint schedule was implemented with nursing staff trained to apply the hand splint during morning ADLs. A review of the physician orders from March 2021 to June 2021 for Resident #62 revealed no order for the application of the left handed splint. A review of Resident #62's medication administration record (MAR) and the treatment administration record (TAR) from March 2021 to June 2021 revealed no order or documentation of the application of a left hand splint. The care plan dated 5/13/2021 revealed Resident	F 688	F688 1. Facility failed to obtain a physician's order to communicate the application of the left-hand splint as recommended by occupational therapy for resident #62. Order for left hand splint was obtained on 6/29/2021 for resident #62. 2. All current residents with splints orders were verified with occupational therapy and MD. This audit will be completed 7/9/2021 by nurse managers. 3. Director of Nursing, unit managers, and/or designee will educate licensed nurses to place order for splints in electronic medical record. This education will be completed by 7/9/2021. Director of Nursing and/or Nurse Managers will audit 5 residents with splints weekly x 12 weeks to ensure orders are in the electronic medical record and that the splints were applied as ordered. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person responsible: Director of	

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F 688	Continued From page 60	F 688	Nursing	

#62 required extensive to total assistance with ADLs and interventions included a referral to occupational therapy and evaluation. There was no focus or intervention for the application of the left hand splint documented on Resident #62's care plan.

On 6/6/2021 at 12:39pm, Resident #62 was observed sitting in her wheelchair with her left wrist turned inward laying on her waist and her fingers on the left hand contracted inward. She stated she had a left handed splint in a drawer, but the nursing staff didn't put the splint on her left hand.

On 6/8/2021 at 9:29am, Resident #62 was observed sitting up in the wheelchair eating breakfast and had received her morning ADLS. The left handed splint was observed lying on top to the dresser in the front of her room.

On 6/9/2021 at 3:07pm in an interview with the Director of Therapy, she stated therapists communicated the use of splints with the nursing staff by writing a telephone order for the physician to sign. She further stated she was unable to locate a therapy order for the use of splints for Resident #62.

On 6/9/2021 at 5:00pm, the Director to Therapy stated she was unable to locate the order for the use of the left handed splint for Resident #62 but stated Resident #62's left upper extremity hand splint was to be applied in the morning after ADLs and was to be worn for 4-6 hours.

On 6/10/2021 at 3:45pm in an interview with the Director of Nursing (DON), she stated therapy recommendations for the nursing staff to apply

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F 688	Continued From page 61	F 688		

splints required a physician's order, and there was no order on Resident #62's chart. She further stated restorative care aides were reassigned to resident care areas due to the COVID pandemic and the use of splints was communicated to the nursing staff on the care plan.

On 6/10/2021 at 4:00pm in an interview with Nurse #8, she stated the therapists applied the left handed splint for Resident #62 and observed Resident #62 removing the splint earlier. When Resident #62 was located by Nurse #8, Resident #62 stated therapy applied the left hand splint that morning and informed her she could take it off when she wanted to.

On 6/10/2021 at 4:40pm, the Director of Therapy provided an order dated 6/10/2021 stating to apply the left upper extremity splint after morning ADLs and to remove after lunch. The order further stated to observe the skin for redness and irritation. She stated therapy filed a form with the MDS nurse and the DON to communicate the therapy orders but was unable to provide a copy of the form. She further stated although the resident could not apply the left hand splint herself, she could remove the left hand splint.

On 6/11/2021 at 9:47am in an interview with Resident #62, she was observed wearing the left handed splint. She stated she tried to wear the left handed splint until lunch time and was able to remove the left handed splint herself. She stated the left handed splint was not applied every day for the last two months and only applied when she remembered to remind the nursing staff. She stated the left handed splint helped her to straighten the left fingers and denied any further

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F 688	Continued From page 62 decline in the use of the left fingers due to not wearing the left handed splint every day. On 6/11/2021 at 9:49am in an interview with the Medication Aide #2, she stated she didn't usually work this assignment and was not sure how the nursing staff were helping Resident #62 with the left handed splint. On 6/11/2021 at 9:52am in an interview with the Administrator, he stated the application of splints by the nursing staff required a physician order, and the therapy department directed and trained the nursing staff on applying splints. On 6/11/21 at 11:54am in an interview with Nurse Aide #3, she stated she was not aware Resident #62 wore a left handed splint and was informed to apply the splint that morning.	F 688		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		7/16/21

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F 692	Continued From page 63 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record review, the facility failed to assess and address weight loss for one of eight residents reviewed for nutrition (Resident #70). Findings included: Review of the medical record revealed Resident #70 was admitted 6/13/2020 with diagnoses including dementia, depression and Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 4/6/2021 indicated Resident #70 was severely impaired for cognition and needed limited assistance for eating with the physical help of one person. The Care Area Assessment indicated an area of nutrition and this area was noted to go to care planning. The care plan dated 2/17/2021 noted a focus of weight loss, with a goal of maintaining current weight through the next review. Interventions included: Administer meds as ordered. Diet as ordered. Monitor intake. Offer substitute meals if dislikes meal served. Weight per facility protocol. Notify MD and RD of weight loss. Labs as ordered. A review of weights revealed from admission there were four weeks of weekly weights. Admission weight was 123 lbs., then 125 lbs. on	F 692	F692 1. Facility failed to assess and address weight loss for resident #70. Resident #70 was weighed on 6/10/2021 and 6/15/2021. Director of Nursing reviewed and addressed resident weight gain on 6/30/2021. 2. Current residents are to be identified to obtained weights according to the interdisciplinary weight variance committee. This will be completed by 7/9/2021. 3. Director of Nursing, unit managers, and/or designee will educate nursing staff on weighing resident according to the interdisciplinary weight variance committee and entering the weight in correctly in the electronic medical. This education will be completed by 7/9/2021. Nurse Managers will review weights weekly x 12 weeks to ensure residents are being weighed according to the interdisciplinary weight variance committee. Director of Nursing will review the weekly weight audits to ensure residents are being weighted according to the	

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F 692	Continued From page 64 6/19/2020, 122.8 lbs. on 6/26/2020, 123.7 lbs. on 7/3/2020, and 120 lbs. on 7/10/2020. Review of orders revealed an order for Speech Therapy (ST) for dysphagia on 6/15/2020. Orders again for ST on 8/28/2020, 11/23/2020 and 3/24/2021. A review of the physician visits revealed the physician visited on 8/15/2020, but there was no weight for the month of August 2020. A review of the Registered Dietician (RD) note on 8/31/2020 indicated Resident #70 's current weight was 95 lbs. which was a 25 lb. decrease in six weeks. The RD noted Resident #70 had received cueing, encouragement and supplementation, and staff reported poor attention at meals. Resident #70 continued to receive Speech Language Therapy (SLT) for dysphagia management, swallowing and cognition. Resident #70 was noted to consistently consume less than 50%. Supplements were noted as health shakes three times daily, fortified health shakes, 60 milliliters (ml) three times daily, which the Resident consistently consumes more than 75%. The RD recommended the fortified health shakes be increased to 90 ml four times per day, and dietary provide double desserts with meals. The RD also recommended an appetite stimulant if there was no contraindication, and the RD would continue to monitor. Documentation of a note on 9/3/2020 from a facility nurse to the physician stated the physician was asked about Resident #70 's weight loss and the recommendation for an appetite stimulant from the RD. The physician stated with the Resident's advanced dementia, he did not think	F 692	interdisciplinary weight variance committee. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 692	Continued From page 65	F 692		

an appetite stimulant was an appropriate intervention. The physician indicated with advanced dementia, decline with weight loss was expected.

Documented weight for Resident #70 on 9/14/2020 was 95 lbs. There was no documented October 2020 weight.

A review of nurse progress notes revealed on 10/16/2020 a facility nurse texted the physician about the family concerns about Resident #70 's eating and weight loss. New orders were noted for a medication often used for appetite stimulation to be given daily.

The documented weight for Resident #70 on 11/5/2020, was 85 lbs.

An RD note dated 11/17/2020 indicated Resident #70 ' s current body weight was 85 lbs. The note stated, "No weight available for October for comparison; unable to determine if weight is now stabilizing with added interventions." The note indicated Resident #70 had lost 38 lbs. since June admission. The weight loss was despite cueing, encouragement and supplementation of the Resident 's poor oral intake. Staff reported poor attention at meals and refuses assistance with meals. The note reported the Resident consistently consumes 50 - 75 % per staff documentation. Supplements are in place to help meet her nutritional needs: health shakes three times daily and fortified health shakes 90 ml. four times per day, with good consumption per staff. Adequate supplementation in place for resident to maintain weight. Will continue to monitor.

An order was noted on 12/23/2020 for weekly

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F 692	Continued From page 66 weights. There was no documentation of any weight in December 2020 or January 2021. Resident #70 had a documented weight of 81.9 lbs. on 3/7/2021. Weights were also documented for April, May and June of 2021. On 6/10/2021 at 4:30 PM, the Director of Nursing stated Resident #70 was on comfort care since she returned from the hospital in late May. On 6/11/2021 at 2:30 PM, the Director of Nursing stated facility policy required monthly weights. The Director of Nursing noted Resident #70 should have been weighed at least, monthly.	F 692		
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 during this review must be documented on a separate, written report that is sent to the	F 756		7/16/21

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F 756	Continued From page 67 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 record reviews and staff, consultant pharmacist, pharmacy Clinical Director, and Nurse Practitioner (NP) interviews, the consultant pharmacist failed to identify and address the facility's need to ensure a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) was time limited in duration and documentation of the rationale for its use beyond 14 days was provided for 1 of 5 residents reviewed for unnecessary medications (Resident #77); and, the facility failed to retain the consultant pharmacist's findings, recommendations, and provider response in the resident's medical record or within the facility so the records were readily available for 1 of 5 residents reviewed for unnecessary medications (Resident #77).	F 756	F756 1. Facility failed to identify and address the facility's need to ensure a psychotropic medication was time limited in duration and documentation of the rationale for its use beyond 14 days for resident #77. Resident #77 is no longer on PRN medication for anxiety and agitation. Facility failed to retain the consultant pharmacist findings, recommendations, and provider response in the residents' medical record or within the facility, so the records were readily available for resident #77.	

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F 756	Continued From page 68 The findings included: 1-a) Resident #77 was admitted to the facility on 1/22/18 with re-entry from a hospital on 8/11/19. Her cumulative diagnoses included non-Alzheimer ' s dementia, anxiety disorder, depression, and unspecified psychosis not due to a substance or known physiological condition. Resident #77's medication orders included an order dated 3/25/20 for 10 milligrams (mg) buspirone (an antianxiety medication) to be given as one tablet by mouth and scheduled to be administered twice daily for anxiety (reordered on 2/15/21). A physician ' s order was written on 9/30/20 for 0.5 mg lorazepam (an antianxiety medication) to be given by mouth every 8 hours as needed for anxiety/agitation for 14 days with a stop date of 10/14/20. Resident #77's September 2020 and October 2020 Medication Administration Records (MARs) revealed the resident received 14 doses of the PRN lorazepam from 9/30/20 to 10/14/20. On 10/24/20, a physician's order was received for 0.5 mg lorazepam to be given as one tablet by mouth as needed (PRN) for anxiety and agitation. This medication order did not include a stop date; and, the order did not include documentation of the rationale to extend the use of the PRN lorazepam beyond 14 days. A review of Resident #77's October 2020 MAR revealed the resident did not receive any doses of PRN lorazepam from 10/24/20 - 10/31/20. The consultant pharmacist's Medication Regimen Review (MRR) dated 11/2/20 included the	F 756	2. All current residents receiving PRN psychotropic medication will be reviewed by the pharmacy consultant. This audit will be completed by 7/9/2021. 3. Regional Nursing Consultant educated Director of Nursing on filing the pharmacy recommendations in a binder to have onsite and give a copy to medical records for scanning in residents chart. This education will be completed by 7/7/2021. Nurse Managers will audit residents reviewed by consultant pharmacists weekly x 12 weeks to ensure pharmacy recommendations are onsite and in residents chart. Director of Nursing and/or designee will review pharmacy recommendations to ensure identification of PRN psychotropic medications have a 14 day stop date and or rational for a stop date greater than 14 days Monday – Friday weekly for 12 weeks. Regional Nursing Consultant will review pharmacy recommendations from the pharmacy consultant to ensure PRN psychotropic medications have a 14 day stop date and/or rational for a stop date greater than 14 days monthly for 3 months. Director of Nursing will review the weekly audit to ensure that pharmacy recommendations are onsite and in the resident’s chart.	

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F 756	Continued From page 69 following statement: "Recommendations: NS (not significant)- TSH (thyroid stimulating hormone) Cont. (Continue) to follow." Resident #77's November 2020 MAR revealed 8 doses of PRN lorazepam were administered to the resident from 11/1/20 - 11/30/20. The consultant pharmacist's MRR dated 12/1/20 included the following statement: "Recommendations: NS- TSH Cont. to follow." Resident #77's December 2020 MAR revealed 9 doses of PRN lorazepam were administered to the resident from 12/1/20 - 12/31/20. The consultant pharmacist's MRR dated 1/1/21 included the following statement: "Recommendations: NS Cont. to follow." Resident #77's January 2021 MAR revealed 5 doses of PRN lorazepam were administered to the resident from 1/1/21 - 1/31/21. The consultant pharmacist's MRR dated 2/1/21 included the following statement: "Recommendations: NS Cont. to follow." Resident #77's February 2021 MAR revealed 4 doses of PRN lorazepam were administered to the resident from 2/1/21 - 2/28/21. The consultant pharmacist's MRR dated 3/1/21 included the following statement: "Recommendations: NS Cont. to follow." Resident #77's March 2021 MAR revealed 5 doses of PRN lorazepam were administered to the resident from 3/1/21 - 3/31/21. The consultant pharmacist's MRR dated 4/1/21 included the following statement: "Recommendations: NS; Cont. to follow." Resident #77's April 2021 MAR revealed 1 dose	F 756	4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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of PRN lorazepam was administered to the resident from 4/1/21 - 4/6/21.

Resident #77's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/6/21. The MDS assessment revealed Resident #77 had severely impaired cognitive skills for daily decision making. Resident #77 was not reported as having any behaviors nor rejection of care. The medication section of the resident's MDS indicated her medications included administration of an antianxiety medication on 7 out of 7 days during the look back period (which included the scheduled buspirone and PRN lorazepam).

Resident #77's April 2021 MAR revealed 2 doses of PRN lorazepam were administered to the resident from 4/6/21 - 4/30/21.

The consultant pharmacist's MRR dated 5/3/21 included the following statement: "Recommendations: NS; Cont. to follow." Resident #77's May 2021 MAR revealed 1 dose of PRN lorazepam was administered to the resident from 5/1/21 - 5/31/21.

The consultant pharmacist's MRR dated 6/2/21 included the following statement: "Recommendations: NS; Cont. to follow." Resident #77's June 2021 MAR revealed the resident did not receive any doses of PRN lorazepam from 6/1/21 - 6/10/21.

From 10/24/20 to 6/10/21, there was no documentation in Resident #77's medical record to indicate the consultant pharmacist addressed the facility's need to ensure an order for PRN lorazepam was time-limited (with a stop date) and documentation for the rationale of implementing a

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PRN order for lorazepam over an extended period of time was provided.

A telephone interview was conducted on 6/10/21 at 9:34 AM with the facility's consultant pharmacist. During the interview, the pharmacist confirmed the abbreviation "NS" frequently used in her MRR progress notes meant "not significant." Upon review of the PRN lorazepam order written for Resident #77 on 10/24/20, the consultant pharmacist confirmed there was no stop date or duration indicated for the order. However, the pharmacist stated she requested Resident #77's PRN lorazepam be discontinued on the nursing recommendations she emailed to the facility in December 2020. No additional pharmacist findings or recommendations were reported to have been made for this resident from October 2020 to the date of this review on 6/10/21.

An electronic copy of the Nursing Summary Report for Resident #77 dated 12/31/20 and authored by the consultant pharmacist was provided for review on 6/11/21 at 12:49 PM. The Nursing Summary Report included a recommendation of "Medium Priority" for Resident #77 which read as follows: "Please consider whether it would be possible to discontinue the PRN Ativan (lorazepam) order in the near future, or make plans to have patient evaluated by MD (Medical Doctor) or NP (Nurse Practitioner) at least once every 4 months while receiving PRN Ativan (lorazepam) to ensure that we are in compliance with CMS (Centers for Medicare and Medicaid Services) regulations." The Nursing Summary Report included blanks for the form to be initialed and dated as completed. Neither of these blanks were filled out.

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An interview was conducted on 6/10/21 at 10:50 AM with Nurse Practitioner (NP) #1. NP #1 was identified as a provider who was involved in the care for Resident #77. During the interview, the NP reviewed Resident #77's paper medical record and history of lorazepam orders. Upon review of the orders, the NP noted the resident ' s PRN lorazepam was initially ordered in September 2020 for a period of 14 days. NP #1 also reported the order dated 10/24/20 continued the PRN order for lorazepam, but this order did not include a stop date. She stated the PRN lorazepam should have been made scheduled at that time if the resident continued to need it.

An interview was conducted on 6/11/21 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the DON was asked what role she would have expected the consultant pharmacist to have with regards to identifying PRN psychotropic medication orders that needed to have a time-limited duration (stop date) and documentation of a rationale for an extended duration of use past 14 days. The DON stated, "I would expect that she would catch things and alert us to it so we can address it promptly." The DON added that if a concern identified by the consultant pharmacist was not addressed by the facility in a timely manner, she would want the pharmacist to call her attention to it.

1-b) Resident #77 was admitted to the facility on 1/22/18 with re-entry from a hospital on 8/11/19. Her cumulative diagnoses included non-Alzheimer's dementia, anxiety disorder, depression, and unspecified psychosis not due to a substance or known physiological condition.

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Resident #77's medication orders included 20 milligrams (mg) citalopram (an antidepressant medication) to be given as one tablet daily for anxiety (order dated 1/30/20).

A review of the resident's electronic medical records included the consultant pharmacist's Medication Regimen Review (MRR) dated 6/3/20. The pharmacist's note included the following statement: "Recommendations: NS (not significant); Cont. (Continue) to follow."

Further review of the resident's paper and electronic medical records revealed there was no documentation in Resident #77 ' s medical record to indicate the consultant pharmacist provided findings of a medication irregularity and/or made recommendations to the facility or physician based on the MRR conducted in June 2020.

Upon request, a Medication Regimen Review form submitted to the Medical Doctor (MD) was obtained from the pharmacy and provided by the facility for review. This form was dated 6/3/20 and requested the MD respond to the following: "The resident currently has orders for Buspar (an antianxiety medication) 5 mg 1 tab (tablet) twice daily, Celexa (citalopram) 20 mg 1 tab once daily, Ativan (lorazepam) 0.5 mg ½ tab every 8 hours, and trazodone (an antidepressant) 50 mg 1 tab at bedtime. There appears to be few documented behaviors. CMS guidelines recommend that a gradual dosage reduction be attempted unless contraindicated and the physician has documented clinical rationale. Resident has had several occurrences of disruptive sounds in the past 30 days. Please assess for a possible dose reduction at this time." The MD agreed with the recommendation and provided a hand-written

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notation to decrease the dose of Celexa to 10 mg once a day. The MD response was dated 6/6/20. On 6/9/20, a physician's order was initiated to reduce the dosage of citalopram to 10 mg citalopram administered once daily.

A telephone interview was conducted on 6/10/21 at 9:34 AM with the facility's consultant pharmacist. During the interview, the pharmacist reported the abbreviation "NS" frequently used in her MRR progress notes meant "not significant." The consultant pharmacist discussed the process employed to communicate her findings and recommendations with the facility. She reported sending the following reports each month: an executive summary, a nursing summary (which included recommendations pertaining to the nursing staff); and Medical Doctor (MD) recommendations. The pharmacist reported any MD recommendations made were sent electronically to multiple individuals, including the facility's Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), MD, psychiatric service, corporate nursing consultant, and corporate Regional consultant for the pharmacy. The consultant pharmacist reported she always recommended the facility keep a pharmacy binder for the pharmacy recommendations and provider responses, scan the recommendations / responses into the residents' electronic medical record, or put a paper copy of these into the residents' medical record.

An interview was conducted on 6/11/21 at 10:48 AM with the facility's corporate Nurse Consultant and the DON. During the interview, the availability of the consultant pharmacist's monthly MRR findings, recommendations, and provider

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responses were discussed. The DON reported when she recently took over the position as DON, she was told that once the signed pharmacist recommendations were addressed and scanned back to the pharmacy, the recommendations could be shredded. She reported these recommendations / responses were shredded accordingly. When asked if the findings and consultant pharmacist recommendations were kept onsite, the Nurse Consultant and DON reported they were not. Upon further inquiry, the Nurse Consultant and DON confirmed these records were not kept onsite even in an electronic format at the time of the survey. They confirmed copies of the pharmacist recommendations and provider responses had to be requested and obtained from the pharmacy.

A telephone interview was conducted on 6/11/21 at 10:28 AM with the Clinical Director for the facility's contracted pharmacy. When the accessibility and onsite availability of the consultant pharmacist's findings and recommendations were discussed, the Clinical Director reported the facility did have access to these documents electronically but may not have known how or where to access them. The Clinical Director reported there had already been an in-service conducted on what the process was supposed to be for the retention of the pharmacist's recommendations. With regards to the lack of accessibility of the records, the Clinical Director stated, "I completely get it." She reiterated she had been in contact with both the consultant pharmacist and the facility to help ensure the necessary records were kept onsite and would be readily accessible from this point going forward.

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1-c) Resident #77 was admitted to the facility on 1/22/18 with re-entry from a hospital on 8/11/19. Her cumulative diagnoses included non-Alzheimer's dementia, anxiety disorder, depression, and unspecified psychosis not due to a substance or known physiological condition.

Resident #77's medication orders included 0.5 mg lorazepam to be given as one tablet by mouth as needed (PRN) for anxiety and agitation (order dated 10/24/20 and continued through 6/10/21). This medication order did not include a stop date; and, the order did not include documentation of the rationale to extend the use of the PRN lorazepam beyond 14 days.

A review of the resident's electronic medical records included the consultant pharmacist's Medication Regimen Review (MRR) dated 12/1/20. The pharmacist's note included the following statement: "Recommendations: NS (not significant) - TSH (thyroid Stimulating Hormone) Cont. (Continue) to follow."

Further review of the resident's paper and electronic medical records revealed there was no documentation in Resident #77's medical record to indicate the consultant pharmacist provided findings of a medication irregularity and/or made recommendations to the facility or physician based on the MRR conducted in December 2020.

An electronic copy of a Nursing Summary Report for Resident #77 dated 12/31/20 and authored by the consultant pharmacist was provided for review by the Clinical Director for the facility's contracted pharmacy on 6/11/21 at 12:49 PM. The Nursing Summary Report included a recommendation of "Medium Priority" for

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Resident #77 which read as follows: "Please consider whether it would be possible to discontinue the PRN Ativan (lorazepam) order in the near future, or make plans to have patient evaluated by MD (Medical Doctor) or NP (Nurse Practitioner) at least once every 4 months while receiving PRN Ativan (lorazepam) to ensure that we are in compliance with CMS (Centers for Medicare and Medicaid Services) regulations." The Nursing Summary Report included blanks for the form to be initialed and dated as completed. Neither of these blanks were filled out.

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responses were discussed. The DON reported when she recently took over the position as DON, she was told that once the signed pharmacist recommendations were addressed and scanned back to the pharmacy, the recommendations could be shredded. She reported these recommendations / responses were shredded accordingly. When asked if the findings and consultant pharmacist recommendations were kept onsite, the Nurse Consultant and DON reported they were not. Upon further inquiry, the Nurse Consultant and DON confirmed these records were not kept onsite even in an electronic format at the time of the survey. They confirmed copies of the pharmacist recommendations and provider responses had to be requested and obtained from the pharmacy.

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F 758	Continued From page 79	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		7/16/21

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F 758	Continued From page 80 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 staff interviews, interviews with the facility ' s consultant pharmacist, Nurse Practitioner (NP) and contracted pharmacy's Clinical Director, and records reviews, the facility failed to obtain documentation for the rationale and duration to extend the use of an as needed (PRN) order for a psychotropic medication beyond 14 days. This was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #77). The findings included: Resident #77 was admitted to the facility on 1/22/18 with re-entry from a hospital on 8/11/19. Her cumulative diagnoses included non-Alzheimer's dementia, anxiety disorder, depression, and unspecified psychosis not due to a substance or known physiological condition. Resident #77's history of medication orders included an order dated 3/25/20 for 10 milligrams (mg) buspirone (an antianxiety medication) to be given as one tablet by mouth and scheduled to be administered twice daily for anxiety (reordered on 2/15/21).	F 758	F758 1. Facility failed to obtain documentation for the rationale and duration to extend the use of an as needed PRN order for a psychotropic medication beyond 14 days of resident #77. Resident #77 is no longer receiving PRN psychotropic medications. 2. All current residents receiving PRN psychotropic medication will be reviewed by the pharmacy consultant to ensure proper rationale if beyond the 14 days duration. Audit will be completed by 7/7/2021. 3. Director of Nursing and/or Assistant Director of Nursing will educate license nurses on obtaining a 14 day stop day on all psychotropic medications and if the duration is longer the nurse is to obtain the rational. This education will be completed by 7/7/2021. Director of Nursing and/or designee will audit Monday-Friday PRN psychotropic	

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F 758	Continued From page 81 A physician's order was written on 9/30/20 for 0.5 mg lorazepam (an antianxiety medication) to be given by mouth every 8 hours as needed for anxiety/agitation for 14 days with a stop date of 10/14/20. Resident #77's September 2020 and October 2020 Medication Administration Records (MARs) revealed the resident received at least one dose of the PRN lorazepam on each of the following dates: 9/30/20, 10/1/20, 10/3/20, 10/5/20, 10/6/20, 10/7/20, 10/8/20, 10/9/20, 10/12/20, 10/13/20, and 10/14/20. On 10/24/20, a physician's order was received for 0.5 mg lorazepam to be given as one tablet by mouth as needed (PRN) for anxiety and agitation. This medication order did not include a stop date; and, the order did not include documentation of the rationale to extend the use of the PRN lorazepam beyond 14 days. The resident's MARs from 10/24/20 through 4/6/21 were reviewed and revealed the following: --10/24/20 - 10/31/20: No doses of PRN lorazepam were documented as administered. --11/1/20 - 11/30/20: 8 doses of PRN lorazepam were documented as administered. --12/1/20 - 12/31/20: 9 doses of PRN lorazepam were documented as administered. --1/1/21 - 1/31/21: 5 doses of PRN lorazepam were documented as administered. --2/1/21 - 2/28/21: 4 doses of PRN lorazepam were documented as administered. --3/1/21 - 3/31/21: 5 doses of PRN lorazepam were documented as administered. --4/1/21 - 4/6/21: 1 dose of PRN lorazepam were documented as administered.	F 758	medications to ensure PRN stop date of 14 days, if duration is greater than 14 days stop date than ensure proper rational. This audit will continue weekly x 12 weeks. If PRN psychotropic medications does not have a stop date nor the proper rational Director of Nursing and/or designee will contact the NP/PA/MD to receive an order for a 14 day stop date and/or rational if stop date is longer than 14 days. Director of Nursing will review the results of the weekly audit to ensure PRN stop date of 14 days and if duration is greater than a 14 day stop date a proper rationale exists. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person Responsible: Director of Nursing	

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Resident #77's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/6/21. The MDS assessment revealed Resident #77 had severely impaired cognitive skills for daily decision making. She required limited assistance with eating, extensive assistance with transfers, and was totally dependent on staff for all of her other Activities of Daily Living (ADLs). Resident #77 was not reported as having any behaviors nor rejection of care. The medication section of the resident's MDS indicated her medications included administration of an antianxiety medication on 7 out of 7 days (which included the scheduled buspirone and PRN lorazepam) during the look back period.

The resident ' s MARs from 10/24/20 through 4/6/21 were reviewed and revealed the following:
--4/6/21 - 4/30/21: 2 doses of PRN lorazepam were documented as administered.
--5/1/21 - 5/31/21: 1 dose of PRN lorazepam were documented as administered.
--6/1/21 - 6/10/21: 0 doses of PRN lorazepam were documented as administered.

A telephone interview was conducted on 6/10/21 at 9:34 AM with the facility's consultant pharmacist. During the interview, the pharmacist was asked what her thoughts were with regards to the extended duration of Resident #77's PRN lorazepam continuing from 10/24/20 to 6/10/21 without a stop date. The pharmacist indicated she would return the call to address this concern. A follow-up telephone interview was conducted on 6/11/21 at 10:07 AM with the consultant pharmacist. When asked about the extended duration of a PRN psychotropic medication (any drug that affects brain activities associated with

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mental processes and behavior) such as lorazepam, the pharmacist reported the initial fill would be for 14 days. She added, "subsequent fills every 4 months are pursuant to the MD order." The consultant pharmacist requested her Clinical Director be contacted for further information.

A telephone interview was conducted on 6/11/21 at 10:28 AM with the Clinical Director of the facility ' s contracted pharmacy. During the interview, the Clinical Director reported it was her understanding that Resident #77's PRN lorazepam was started in September 2020 with an order for 14 days, the resident was re-evaluated, and the PRN lorazepam was restarted. She stated the pharmacy's policy indicated a refill could be up to 4 months on the second fill for all PRN psychotropic medications (not including antipsychotics). The Clinical Director stated, "The problem is it should have been stopped and restarted."

An interview was conducted on 6/10/21 at 10:50 AM with Nurse Practitioner (NP) #1. NP #1 was identified as a provider who was involved in the care for Resident #77. During the interview, the NP was asked about the protocol for ordering a PRN psychotropic medication such as lorazepam. She reported a PRN psychotropic medication would usually be initially ordered for a period of 14 days. The resident would be re-evaluated every 14 days and/or refer for a psychiatry consultation. The NP reported if a resident needed to continue on the medication, it could be scheduled for administration instead of being given on a PRN basis. The NP reviewed Resident #77's paper medical record and history of lorazepam orders. Upon review of the orders,

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F 758	Continued From page 84 she noted the PRN lorazepam was initially ordered in September 2020 for a period of 14 days. NP #1 also reported a prescriber order dated 10/24/20 continued the PRN order for lorazepam but did not put a stop date on it. She stated the PRN lorazepam should have been made scheduled at that time if the resident continued to need it. An interview was conducted on 6/10/21 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the DON was informed of the concern identified where an order for PRN lorazepam was continued from 10/24/20 up until the date of this review for Resident #77. When asked, the DON reported she agreed with the NP's expectation that a medication such as lorazepam could be ordered on a PRN basis for 14 days, then the resident reassessed and an appropriate plan developed. Such a plan could include options such as reordering the PRN medication for an additional 14 days, order the medication to be administered on a scheduled basis, and/or request a psychiatric evaluation.	F 758		
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	F 761		7/16/21

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F 761	Continued From page 85 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label medications with the minimum identifying information required (including a resident's name) in 3 of 4 medication carts observed (Med Cart 1 Station 1; Med Cart 2 Station 1; and Med Cart 4 Station 2); failed to discard expired medications stored in 3 of 4 medication carts (Med Cart 1 Station 3; Med Cart 4 Station 2; and Med Cart 1 Station 1) and in 1 of 1 medication storage room observed (Station 1 Medication Store Room); and, failed to store medications in accordance with the manufacturer's storage instructions in 2 of 4 medication carts observed (Med Cart 4 Station 2; and Med Cart 1 Station 3). The findings included: 1-a) In the presence of Nurse #1, an observation was conducted of Med Cart 1 Station 1 on 6/6/21 at 7:25 PM. The observation revealed an opened 10 milliliter (ml) vial of Novolin insulin was stored on the medication cart. A date written on white	F 761	F761 1. Facility failed to label medications with the minimum identifying information required (including a resident's name), discard expired medications in medication carts and medication room. Failed to store medications in accordance with the manufacturer's storage instructions. On 6/10/2021 expired medications were removed and discarded properly. Medications were properly labeled. Medications were stored according to manufacturer's instructions. 2. All medication carts and medication rooms were audited by the pharmacy consultant. Expired medications were removed and discarded properly. Medications were properly labeled. Medications were stored according to manufacturer's instructions. This audit was completed by 7/7/21.	

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F 761	Continued From page 86 adhesive tape affixed to the insulin vial indicated it had been opened on 6/3/21. However, no resident name or other identifying information was found on the insulin vial. When the nurse was asked how she would know who this insulin belonged to, she stated, "I don't know." Nurse #1 reported the insulin vial would need to be discarded. An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility ' s storage of medications were discussed. The DON reported that insulin dispensed from the pharmacy should be labeled and only used for the person identified on the label. She stated the facility did keep some "stock insulin" in a locked box located in the Station 2 medication storage room. The DON reported if an insulin vial was taken from these stock meds, nursing staff needed to put the resident's name on the vial with the date it was opened. The DON stated that one of her expectations was for the Unit Managers to be sure medications were stored according to the manufacturer's instructions, labeled appropriately for a designated resident when they needed to be, and dated when the medication was opened. 1-b) In the presence of Nurse #4, an observation was conducted of Med Cart 2 Station 1 on 6/7/21 at 8:00 AM. The observation revealed an opened 10 milliliter (ml) vial of Humulin N insulin was stored on the medication cart. The insulin vial was dated to indicate it had been opened on 5/23/21. However, no resident name or other identifying information was found on the insulin vial. At that time, the nurse was asked how she would know who the vial of insulin had been used for. Nurse #4 responded by stating that since	F 761	3. Director of Nursing and/or Assistant Director of Nursing will educate license nurses and medication aides on removing and discarding expired medications properly, labeling medications with minimum identifying information and storing medications according to manufacturer's storage instructions. This education will be completed by 7/9/2021. Director of Nursing and/or designee will audit medication carts and medication rooms weekly x 12 weeks to ensure that medications are labeled with minimum identifying information required and that medications are stored in accordance with the manufacturer’s storage instructions. The weekly audit will include all medication carts and medication rooms. Director of Nursing will review the results of the audit weekly to ensure that medications are labeled with minimum identifying information required and that medications are stored in accordance with the manufacturer’s storage instructions. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person responsible: Director of	

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there was no name on the vial, she could not use it for any resident and it needed to be discarded.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported that insulin dispensed from the pharmacy should be labeled and only used for the person identified on the label. She stated the facility did keep some "stock insulin" in a locked box located in the Station 2 medication storage room. The DON reported if an insulin vial was taken from these stock meds, nursing staff needed to put the resident's name on the vial with the date it was opened. The DON stated that one of her expectations was for the Unit Managers to be sure medications were stored according to the manufacturer's instructions, labeled appropriately for a designated resident when they needed to be, and dated when the medication was opened.

1-c) In the presence of Nurse #4, an observation was conducted of Med Cart 2 Station 1 on 6/7/21 at 8:00 AM. The observation revealed an opened 10 milliliter (ml) vial of Novolin N insulin was stored on the medication cart. The insulin vial was dated to indicate it had been opened on 6/3/21. However, no resident name or other identifying information was found on the insulin vial. At that time, the nurse was asked how she would know who the vial of insulin had been used for. Nurse #4 responded by stating that since there was no name on the vial, she could not use it for any resident and it needed to be discarded.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the

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facility's storage of medications were discussed. The DON reported that insulin dispensed from the pharmacy should be labeled and only used for the person identified on the label. She stated the facility did keep some "stock insulin" in a locked box located in the Station 2 medication storage room. The DON reported if an insulin vial was taken from these stock meds, nursing staff needed to put the resident's name on the vial with the date it was opened. The DON stated that one of her expectations was for the Unit Managers to be sure medications were stored according to the manufacturer's instructions, labeled appropriately for a designated resident when they needed to be, and dated when the medication was opened.

1-d) In the presence of Nurse #1, an observation was conducted of Med Cart 1 Station 1 on 6/6/21 at 7:25 PM. The observation revealed an opened 250/50 Wixela Inhub inhaler (a medication used for the treatment of asthma or chronic obstructive pulmonary disease) with 30 doses remaining was stored on the medication cart. The inhaler was no longer in the protective foil tray and was not stored in the manufacturer's box. No resident name or other identifying information were found on the inhaler. Upon review, Nurse #1 stated she thought she knew who the inhaler belonged to. When asked if she could use the inhaler for that resident without the identifying information to ensure it belonged to that resident, the nurse stated, "No."

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported any inhaler that was not labeled with a resident's name should be thrown

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out and another one ordered for the resident. The DON stated that one of her expectations was for the Unit Managers to be sure medications were stored according to the manufacturer's instructions, labeled appropriately for a designated resident when they needed to be, and dated when the medication was opened.

1-e) In the presence of Nurse #2, an observation was conducted of Med Cart 4 Station 2 on 6/6/21 at 8:22 PM. The observation revealed an opened 100 micrograms (mcg) / 25 mcg Breo Ellipta inhaler (a medication used for the treatment of asthma or chronic obstructive pulmonary disease) with 10 doses remaining was stored on the medication cart. The inhaler was no longer in the protective foil tray and was not stored in the manufacturer's box. No resident name or other identifying information were found on the inhaler. Upon review, Nurse #2 stated she needed to "throw away" the inhaler.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility ' s storage of medications were discussed. The DON reported any inhaler that was not labeled with a resident's name should be thrown out and another one ordered for the resident. The DON stated that one of her expectations was for the Unit Managers to be sure medications were stored according to the manufacturer's instructions, labeled appropriately for a designated resident when they needed to be, and dated when the medication was opened.

2-a) In the presence of Nurse #3, an observation was conducted of Med Cart 1 Station 3 on 6/6/21 at 8:48 PM. The observation revealed an opened

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stock bottle of 100 micrograms of Vitamin B12 had approximately 90 tablets remaining in the bottle. The bottle of Vitamin B12 was labeled with a manufacturer's expiration date of January 2021.

An interview was conducted with Nurse #3 on 6/6/21 at 9:00 PM. During the interview, the nurse confirmed the stock bottle of Vitamin B12 tablets was expired and needed to be discarded.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported she would expect expired medications to be discarded and replaced.

2-b) In the presence of Nurse #3, an observation was conducted of Med Cart 1 Station 3 on 6/6/21 at 8:48 PM. The observation revealed an opened stock box containing 51 tablets of 325 milligrams ferrous sulfate (iron) in bubble-pack packaging had a manufacturer's expiration date of February 2021.

An interview was conducted with Nurse #3 on 6/6/21 at 9:00 PM. During the interview, the nurse confirmed the stock box of iron tablets was expired and needed to be discarded.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported she would expect expired medications to be discarded and replaced.

2-c) In the presence of Nurse #2, an observation was conducted of Med Cart 4 Station 2 on 6/6/21

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at 8:22 PM. The observation revealed an opened stock bottle of 50 milligrams (mg) / 8.6 mg Senna Plus (a combination laxative medication) containing approximately 50 tablets was stored on the medication cart. The manufacturer's expiration date printed on the bottle was March 2021.

An interview was conducted with Nurse #2 on 6/6/21 at 8:33 PM. The nurse confirmed the tablets in the bottle of Senna Plus were expired and she needed to, "Toss these."

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported she would expect expired medications such as the Senna Plus to be discarded and replaced with a new bottle from the med storage room.

2-d) In the presence of Nurse #2, an observation was conducted of Med Cart 4 Station 2 on 6/6/21 at 8:22 PM. The observation revealed 7 tablets of Culturelle stored in a blister pack with no expiration date were stored in the top drawer of the medication cart. The blister pack was not stored in the manufacturer's box; no expiration date could be located on the packaging.

An interview was conducted with Nurse #2 on 6/6/21 at 8:33 PM. The nurse confirmed there was no expiration date on the Culturelle tablets. She reported she needed to, "Toss these."

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the

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facility's storage of medications were discussed. The DON reported she would expect the Culturelle with no expiration date to have been thrown out right away and replaced with new medication from the med storage room.

2-e) In the presence of Nurse #1, an observation was conducted of Med Cart 1 Station 1 on 6/6/21 at 7:25 PM. The observation revealed an opened stock bottle of 10 milligrams (mg) cetirizine (an antihistamine) containing approximately 100 tablets was stored on the medication cart. The manufacturer's expiration date printed on the bottle was April 2021. When asked, Nurse #1 confirmed this stock bottle of medication was expired and needed to be disposed of.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported she would expect the cetirizine to have been thrown out right away and replaced with a new bottle from the med storage room.

2-f) In the presence of Nurse #1, an observation was conducted of Station 1 Medication Store Room on 6/6/21 at 7:28 PM. The observation revealed an opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the refrigerator. A hand-written date indicated the Tuberculin PPD medication was opened on 5/1/21. The manufacturer's labeling on the box containing the Tuberculin PPD solution read, in part: "Discard opened product after 30 days." Upon review of the vial and information provided by the manufacturer's storage instructions on the

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label, Nurse #1 confirmed the vial of Tuberculin PPD solution was expired and needed to be discarded.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility ' s storage of medications were discussed. The DON reported she would expect the expired vial of PPD solution to have been thrown out.

3-a) In the presence of Nurse #2, an observation was conducted of Med Cart 4 Station 2 on 6/6/21 at 8:22 PM. The observation revealed a 470 milliliter (ml) bottle of 250 milligrams (mg) per 5 ml gabapentin solution (a medication which may be used to treat neuropathic or nerve pain) dispensed for Resident #83 was stored on the medication cart. The bottle was not cool or cold to the touch. Two pharmacy auxiliary stickers affixed to the bottle indicated the medication needed to be refrigerated. When asked, Nurse #2 reported this medication needed to be "put in the refrigerator." Storage information from the manufacturer provided instructions to store gabapentin oral solution refrigerated at 2o - 8o Celsius (36o- 46o Fahrenheit).

A review of Resident #83's physician orders revealed there was a current order for 300 mg / 6 ml (a concentration equivalent to 250 mg per 5 ml) gabapentin solution to be given as 8 ml by mouth or tube three times daily for pain.

An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported since the gabapentin solution

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F 761	Continued From page 94 had been kept at room temperature in the med cart, it should have been discarded and a refrigerated bottle of the gabapentin used for this resident. 3-b) In the presence of Nurse #3, an observation was conducted of Med Cart 1 Station 3 on 6/6/21 at 8:48 PM. The observation revealed an opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the top drawer of the med cart. The vial was not cold or cool to the touch. A hand-written date indicated the Tuberculin PPD medication was opened on 5/6/21. The vial was stored in the manufacturer's box with storage instructions which read, in part: "Store at 2o - 8o C (35o-46o F). Do not freeze. Protect from light. Discard opened product after 30 days." An interview was conducted with Nurse #3 on 6/6/21 at 9:00 PM. During the interview, the nurse reported the vial of PPD solution needed to be refrigerated, However, she also stated the PPD vial was expired so it needed to be discarded. An interview was conducted on 6/9/21 at 9:00 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported she would have expected this vial of PPD solution to have been thrown out.	F 761		
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 -	F 812		7/16/21

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F 812	Continued From page 95 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 observation and staff interviews the facility failed to ensure that food items that had been opened were labeled and dated. The facility also failed to store items off the floor. This was evident in 1 of 2 kitchen observations. Findings included: An observation of the facility kitchen on 6/6/2021 at 11:35AM revealed the following: 1. a. The walk-in refrigerator had an opened 2-pound package of cheese slices. The package was re-wrapped in plastic wrap but was not dated to indicate when the original package of cheese was opened. b. The walk-in refrigerator had 1 clear plastic pitcher that contained approximately 4 cups yellow-colored liquid. The top opening of the pitcher was covered in plastic wrap, but there was no label or date on the pitcher to identify the liquid or the date when the liquid was made or opened.	F 812	F812 1. Facility failed to ensure that food items that had been opened were labeled and dated. The walk-in refrigerator had an opened 2- pound package of cheese slices, 3- pound loaf of cream cheese, bag of vanilla wafers, and 1 clear plastic pitcher that contained approximately 4 cups yellow-colored liquid. The dry storage area had 1 zip-lock bag that contained an opened 16-ounce bag of mini marshmallows. The dry storage area had 2 boxes of 20- ounce foam cups stored on the floor. The dry storage area had 1 box of hinged foam containers stored on the floor. Items were discarded on 6/6/2021 Assistant Dietary Manager. 2. Assistant Dietary Manager will audit	

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F 812	Continued From page 96 c. The walk-in refrigerator had an opened 3-pound loaf of cream cheese that had been re-wrapped in plastic wrap. There was no date on the package to indicate when the cream cheese was originally opened. d. The dry storage area had 1 zip-lock plastic bag that contained 1 opened bag of vanilla wafers. There was no label or date to indicate when the vanilla wafers were originally opened. e. The dry storage area had 1 zip-lock bag that contained an opened 16 ounce bag of mini marshmallows. The bag was not labeled or dated to indicate when the marshmallows were originally opened. 2 a. The dry storage area had 2 boxes of 20-ounce foam cups stored on the floor. b. The dry storage area had 1 box of hinged foam containers stored on the floor. A staff interview with a dietary staff member that works as a cook and a dietary aide was conducted on 6/11/2021 at 9:35 AM revealed that all opened food items should be re-wrapped, labeled and dated. She also stated the boxes of cups and hinged containers should be stored on the shelves in the dry storage area. A staff interview with the Assistant Dietary Manager on 6/7/2021 at 9:50 AM revealed the food items in the walk-in refrigerator and dry storage area should be labeled and dated after they are opened. She also reported that no items should be stored on the floor in the dry storage area. She stated the boxes of cups and hinged containers should have been stored on the shelves in the dry storage area. A staff interview with the administrator on	F 812	the kitchen to ensure all opened items were properly dated and items were stored properly off the floor. This audit will be completed by 7/7/2021. 3. Administrator educated the dietary staff on label and dating opened items and storing items in proper areas off the floor. This education will be completed by 7/9/2021. Assistant Dietary Manager will audit the kitchen to ensure open items are dated and items are stored properly. This audit will be conducted 5 x per week x 12 weeks. Administrator will review results of the audits to ensure that open items are dated and items are stored properly. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) committee by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 812	Continued From page 97 6/7/2021 at 10:25 AM revealed that all items in the kitchen should be stored, labeled and dated according to regulations.	F 812		