STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(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 7/30/23 through 8/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LNYM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 7/30/23 through 8/2/23. Event ID# LNYM11. The following intakes were investigated: NC00192841 and NC00204281. 5 of the 5 complaint allegations did not result in deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		8/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/20/2023

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

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F 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, interview with the Ombudsman and record reviews, the facility failed to provide the resident a written	F 623	1) Resident # 56 and Resident # 58 returned to the facility. The Social Services Director notified	

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Continued From page 3

notification for the reason for transfer to the hospital and failed to provide a copy of the transfer/discharge notice to the Ombudsman for 2 of 4 residents (Resident #56 and Resident #58) reviewed for hospitalization.

Findings included:

1. Resident #56 was admitted to the facility on 5/30/23. He was listed in the electronic health record as his own responsible party.

The medical record demonstrated the resident was transferred to the hospital on 6/28/23 due to a change in condition. Resident #56 returned to the facility on 7/9/23. No written notice of transfer was documented to have been provided to the resident or Ombudsman.

The significant change Minimum Data Set assessment dated 7/9/23 revealed Resident #56 was cognitively intact.

On 8/1/23 at 3:26 PM an interview was completed with Nurse #1. She shared Resident #56 demonstrated a change in condition on 6/28/23 and she assisted with his transfer to the hospital. She explained when a resident was transferred to the hospital, the facility sent the following paperwork with the resident: medication administration record, face sheet, recent lab work, and clinical information about the resident. She said she had not sent a written transfer/discharge notice or provided one to Resident #56 when he was sent to the hospital.

During an interview with Resident #56 on 8/2/23 at 10:15 AM, he said the facility had not provided him a written notice of transfer when he was sent

F 623

the ombudsman on 08/08/2023. No residents were affected related to this citation.

2) A quality review was completed by the Social Service Director of the last 30 days of
discharges to identify notification of transfer/ discharge notice to responsible party as well as
ombudsman for residents that transferred to the hospital on 08/22/2023. 3 were resident were
identified as transferred/ discharge to the hospital and notice was sent along with notification to
ombudsman on 08/22/2023.

3) The Vice President of Operations educated the Executive Director, Social Service Director
and Director of Nursing by 08/17/2023 regarding to provide written notification of transfer /
discharge notice to the resident and or resident representative of residents transferred to the
hospital and provide a copy of the transfer/ discharge notice to the ombudsman of residents
transfer to the hospital. Licensed nurses were educated by the Executive Director and or Director
of Nursing to provide transfer/ discharge notice to the resident upon transfer to the hospital by
08/22/2023.

4) The Executive Director, Director of

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F 623	Continued From page 4 to the hospital on 6/28/23. The Social Worker (SW) was interviewed on 8/1/23 at 3:37 PM. She stated typically someone at the facility notified the Ombudsman when a resident was discharged from the facility, but added she was not the staff member responsible for notifying the Ombudsman. A telephone interview was conducted with the Ombudsman on 8/1/23 at 3:57 PM. She reported the facility sent her a notice of transfer/discharge when a 30 day notice was provided to the resident by the facility. She said the facility had not sent her notification when a resident was transferred to the hospital and verified she had not been notified when Resident #56 was sent to the hospital. On 8/2/23 at 9:37 AM an interview was completed with the Executive Director. She stated the facility only sent written notification to a resident if it was "a true 30 day notice." She verified the facility had not been sending transfer/discharge notices when a resident went to the hospital. She added the facility had kept a log of transfers to the hospital but had not sent the list to the Ombudsman. The Executive Director added it was the responsibility of the SW to send the list of discharges to the Ombudsman monthly, but there had been some changes in the SW department and it had not been consistently done. 2. Resident #58 was admitted to the facility on 10/21/22. The quarterly Minimum Data Set assessment dated 4/17/23 revealed Resident #58 was not	F 623	Nursing and or Social Service Director will conduct random quality of reviews of patients identified as transferred/ discharge to the hospital 3 times a week for 8 weeks and 1 times a week for 4 weeks to ensure that the resident and or resident representative was provided written notification and the ombudsman was notified . The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff	

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F 623	Continued From page 5 cognitively intact. She was able to ambulate with little assistance. The medical record demonstrated the resident was transferred to the hospital on 5/9/23 and due to a fall. Resident #58 returned to the facility on 5/16/23. No written notice of transfer was documented to have been provided to the resident or Ombudsman. The Social Worker (SW) was interviewed on 8/1/23 at 3:37 PM. She stated typically someone at the facility notified the Ombudsman when a resident was discharged from the facility, but added she was not the staff member responsible for notifying the Ombudsman. On 8/3/23 at 10:30 AM the Administrator stated she was not familiar with the transfer/discharge form that included a portion stating that the ombudsman should be notified of all discharges, including hospital transfers, from the facility. She stated the facility only sent written notification to a resident if it was a 30-day notice of discharge. She stated the facility had not been sending transfer/discharge notices when a resident went to the hospital.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		8/22/23

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F 625	Continued From page 6 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to provide the resident a written notification of the bed hold policy upon a resident's transfer to the hospital for 2 of 4 residents (Resident #56 and Resident #58) reviewed for hospitalization. Findings included: 1. Resident #56 was admitted to the facility on 5/30/23. He was listed in the electronic health record as his own responsible party. The medical record demonstrated the resident was transferred to the hospital on 6/28/23 due to a change in condition. Resident #56 returned to the facility on 7/9/23. No written notice of the	F 625	1) Resident # 56 and Resident # 58 returned to the facility. No residents were affected related to this citation. 2) A quality review was completed by the Social Service Director and or Business Office Manager of the last 30 days of discharges to identify notification to resident and or responsible party of the bed hold policy for residents that transferred to the hospital on 08/22/2023. 3 were resident were identified as transferred/ discharge to the hospital and bed hold policy notice was sent 08/22/2023. No other residents were	

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F 625	Continued From page 7 facility's bed hold policy was documented to have been provided to the resident. The significant change Minimum Data Set assessment dated 7/9/23 revealed Resident #56 was cognitively intact. On 8/1/23 at 3:26 PM an interview was completed with Nurse #1. She shared Resident #56 demonstrated a change in condition on 6/28/23 and she assisted with his transfer to the hospital. She explained when a resident was transferred to the hospital, the facility sent the following paperwork with the resident: medication administration record, face sheet, recent lab work, and clinical information about the resident. She said she had not sent the bed hold policy or provided one to Resident #56 when he was sent to the hospital. During an interview with Resident #56 on 8/2/23 at 10:15 AM, he said the facility had not provided him a copy of the bed hold policy when he was sent to the hospital on 6/28/23. The Business Office Manager was interviewed on 8/1/23 at 3:33 PM. She explained the bed hold policy was provided to a resident at the time of admission. Additionally, the charge nurse provided the bed hold policy to the resident when they were transferred to the hospital. On 8/2/23 at 9:37 AM an interview was completed with the Executive Director. She stated staff were supposed to send the bed hold policy when a resident was transferred to the hospital. She explained the nurses used to send a packet of information with the resident that included the bed hold policy. Recently, the facility transitioned	F 625	identified. 3) The Vice President of Operations educated the Executive Director, Social Service Director, Business Office Manager and Director of Nursing by 08/17/2023 regarding to provide written notification of the bed hold policy to the resident and or resident representative upon transfer to the hospital. Licensed nurses were educated by the Executive Director and or Director of Nursing to provide bed hold policy to the resident upon transfer to the hospital by 08/22/2023. 4) The Executive Director, Business Office Manager and or Social Service Director will conduct random quality of reviews of patients identified as transferred/ discharge to the hospital 3 times a week for 8 weeks and 1 times a week for 4 weeks to ensure that the resident and or resident representative was provided bed hold policy . The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance	

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F 625	Continued From page 8 from a packet of information that was kept at the nurse's desk to computer generated forms and nurses hadn't included the bed hold policy when they sent a resident to the hospital. 2. Resident #58 was admitted to the facility on 10/21/22. The quarterly Minimum Data Set assessment dated 4/17/23 revealed Resident #58 was not cognitively intact. She was able to ambulate with little assistance. The medical record demonstrated the resident was transferred to the hospital on 5/9/23 and due to a fall. Resident #58 returned to the facility on 5/16/23. No written notice of the facility's bed hold policy was documented to have been provided to the resident's responsible party. The Business Office Manager was interviewed on 8/2/23 at 2:35 PM. She stated the bed hold policy was provided to a resident at the time of admission and then the nurse in charge during the time of transfer would provide anything else that was needed. On 8/3/23 at 3:30 PM, the Executive Director stated that the bed hold policy was provided to the resident and/or resident representative during admission and it was part of the admission documents. She stated she was not aware they needed to send the bed hold policy each time a resident was transferred to the hospital. She also stated that the facility recently moved to computer generated transfer packets and the bed hold may have been a part of the packet in the past but was inadvertently omitted currently.	F 625	Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		8/22/23

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F 656	Continued From page 9 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 10 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 2 of 17 residents (Residents #1 and #55) reviewed for comprehensive care plans. Findings included: 1. Resident #1 was admitted to the facility on 1/6/23. The admission Minimum Data Set (MDS) assessment dated 1/13/23 revealed an active discharge plan was in place for the resident to return to the community. The quarterly MDS assessment dated 7/13/23 indicated Resident #1 was cognitively intact. The comprehensive care plan, updated 7/14/23, did not include information that addressed discharge plans or goals. In an interview with Resident #1 on 8/1/23 at 2:36 PM, he shared his discharge plan was to remain in the facility for long term care. On 8/1/23 at 1:57 PM an interview was completed with the Social Worker (SW). She typically wrote	F 656	1) The Social Services Director updated the discharge care plan for resident # 1 and resident # 55 on 08/01/2023. 2) The Social Service Director conducted a quality review of residents admitted to the facility within the last 30 days to ensure discharge care plan was in place by 08/17/2023. No residents were identified as not having a discharge care plan in place. 3) The Executive Director educated the MDS nurse and Social Service Director to develop care plan that addresses discharge goals and plans by 08/22/2023. 4) The Executive Director and or MDS nurse will conduct random quality of reviews of 10 residents care plans to ensure discharge care is in place 3 times a week for 8 weeks and 1 times a week for 4 weeks to ensure that the resident and or resident representative was provided bed	

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the care plan that addressed discharge plans and goals for all the residents. She stated when Resident #1 initially came to the facility, his discharge goal was to return to the community. After he completed therapy, it was determined that he needed a higher level of care and so he remained at the facility for long term care. The SW acknowledged there was not a discharge care plan included in Resident #1's comprehensive care plan and said she thought she hadn't completed one since the resident's discharge plans were uncertain when his care plan was developed by the interdisciplinary team.

The MDS Coordinator was unavailable for interview.

During an interview with the Executive Director on 8/2/23 at 2:57 PM she stated a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. She added the SW had been new to the SW role at the facility and didn't think she knew she could create a care plan that indicated the discharge plan was unknown.

2. Resident #55 was admitted to the facility on 5/31/23.

The admission MDS assessment dated 6/7/23 revealed Resident #55 was cognitively intact and an active discharge plan was in place for the resident to return to the community.

The comprehensive care plan, updated 7/12/23, did not include information that addressed discharge plans or goals.

F 656

hold policy . The results of the Quality Improvement Monitoring will be reported to the Quality
Assurance Performance Improvement Committee by the Executive Director and or Director of
Clinical Services to ensure compliance is achieved and maintained. The Executive Director will
present the Plan of Correction to Quality Assurance Performance Improvement Committee and
oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality
Assurance Performance Improvement Committee members consist of but not limited to the
Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social
Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(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 656	Continued From page 12 On 8/1/23 at 1:57 PM an interview was completed with the SW. She typically wrote the care plan that addressed discharge plans and goals for all the residents. The SW acknowledged there was not a discharge care plan included in Resident #55's comprehensive care plan and said she thought she hadn't completed one since the resident's discharge plans were uncertain when his care plan was developed by the interdisciplinary team. The MDS Coordinator was unavailable for interview. During an interview with the Executive Director on 8/2/23 at 2:57 PM she stated a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. She added the SW had been new to the SW role at the facility and didn't think she knew she could create a care plan that indicated the discharge plan was unknown.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		8/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 13 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 secure medicated treatments left in an unattended treatment cart for 1 of 1 treatment cart. The findings included: During wound care observation on 8/1/23 at 10:53 AM, Nurse #1 was observed to push the treatment cart against the wall on the 200 hall and entered a resident room and closed the door to perform wound care. The cart lock was not pushed in indicating a locked position. Observation of Treatment Cart #1 revealed the top drawer to contain topical ointments. The second drawer contained medicated dressings and bandages. The bottom drawer contained resident prescribed medicated creams for both the 100 and 200 halls. On 8/1/23 at 10:58 AM, residents were observed ambulating in the hallway near the unlocked cart.	F 761	1) The treatment cart was in the medication room on 08/02/2023. The pharmacy delivered the treatment cart key on 08/03/2023. The licensed nurse was educated to ensure treatment cart was not left unlocked and unattended. It must remain locked at all times. 2) A quality review was completed by the Director of Nursing and or Nurse Managers on 08/03/2023 to ensure treatment cart locked. 3) The Executive Director re-educated the Director of Nursing on ensuring treatment cart remain locked at all times when unattended by 08/17/2023. The Director of Nursing re-educated licensed nurses and medication aides on ensuring treatment cart remains locked at all times when unattended by 08/17/2023. 4)) On 08/21/2023, the Executive Director will present the Plan of Correction to	

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F 761	Continued From page 14 An interview on 8/1/23 at 11:00 AM with Nurse #1 revealed that she was aware the treatment cart should be locked when she walked away from it but she stated that she did not have a key. She stated she had worked at the facility for two months and had made a request for the pharmacy to provide her with a key. She stated that she had to get one from the nurse on the other cart to unlock it and was unable to do that without going back and forth after each wound treatment. Nurse #1 stated that she would turn the cart around so it faced the wall while she was out of sight and in a room with a resident. In an interview with the Administrator on 8/3/23 at 2:30 PM, she stated that she was aware that was a problem when Nurse #1 had begun working at the facility but she had thought it had been taken care of already. She stated that she would contact the pharmacy and have that taken care of immediately.	F 761	Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director or Director of Clinical Services and or Nursing Supervisor. The Executive Director will report the results of the Quality Improvement Monitoring to the Quality Assurance Performance Improvement Committee and or Director of Clinical Services to ensure compliance is achieved and maintained. The Director of Nursing and or Nurse Managers will conduct random quality reviews of the treatment cart to ensure the cart is locked two times week for four weeks, one times weekly for four weeks and bi-weekly for four weeks. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.	