STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/7/23 through 8/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #180E11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/7/23 through 8/10/23. Event ID# 180E11. The following intakes were investigated NC00195142, NC00197861, NC00200519, NC00200710, NC00197881, NC00200828, NC00203861. 11 of the 11 complaint allegations did not result in a deficiency.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		9/7/23

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

Electronically Signed | 09/01/2023

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F 755	Continued From page 1 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacy interviews, the facility failed to complete the shift change inventory sheet consistently and accurately for 4 of 7 medication carts reviewed. Findings included: Review of the policy for "Narcotic Reconciliation Protocol" provided by the facility dated 5/30/23 stated in part: - The Director of Nursing or Nurse Manager shall reconcile narcotics monthly on or before the 15th of each month. - The reconciliation audit will include review of each narcotic book for shift count, narcotic count, narcotic page count and that the narcotics are stored with a double lock and key system. - Narcotic Management includes: o Assuring the Narcotic Shift Count is performed. 1 a. Review of the West Annex #1 medication cart with Nurse #3 revealed the Shift Change Controlled Substance Inventory Count sheet from 7/17/23 7:00 AM - 8/9/23 7:00 AM were missing	F 755	1.The facility failed to assure that the Shift Change Controlled Substance Inventory Count Sheets were properly documented on for completion during shift change by Licensed Nurses and Certified Medication Aides reporting on and off each shift. 2. Residents who have Physician's orders to receive Controlled Substance have the potential to be affected. 3. The Director of Nursing initiated 100% education in-service to all Licensed Nurses and Certified Medication Aides on 8/9/2023 to complete the Shift Change Controlled Substance Inventory Count Sheets at the beginning and end of each shift documenting signature on the Shift Change Controlled Inventory Count Sheet on the medication cart. In-service will be completed by 9/7/2023. Any Licensed Nurses and Certified Medication Aides that have not worked and/or not received education after 9/7/203 will not be permitted to assume responsibility of Medication med pass without receiving	

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F 755	Continued From page 2 the following entries: - 7 of 90 controlled substance card counts were not completed - 3 of 45 nurse signatures for "coming on duty" were missing - 3 of 45 nurse's signatures for "going off duty" were missing An interview was conducted with Nurse #3 on 8/9/23 at 1:18 PM. She revealed that all narcotics were stored in the medication cart unless they needed to be refrigerated. At the start of a shift, the departing and oncoming nurses counted and signed off on the shift change inventory sheet. Nurse #3 indicated that if the departing nurse did not count or sign the sheet, then she would have notified the Unit Manager or Director of Nursing (DON). She stated that every date and shift needed to be signed and counted. Nurse #3 revealed that she stated she did not write down the count of narcotics on 8/4/23 because "it was a mistake." b. Review of the West Annex #2 medication cart with Nurse #6 revealed the Shift Change Controlled Substance Inventory Count sheet from 7/20/23 7:00 PM - 8/9/23 7:00 AM were missing the following entries: - 8 of 78 controlled substance card counts were not completed - 1 of 39 nurse signatures for "coming on duty" were missing - 5 of 39 nurse's signatures for "going off duty" were missing Nurse #6 was interviewed on 8/9/23 at 1:36 PM, and she revealed that she forgot to sign as the "going off duty" nurse on 7/31/23 when she finished her shift.	F 755	the aforementioned education from the Director of Nursing, Staff Development Coordinator and/or Nursing Administrative Designee. The facility will also implement the Shift Change Controlled Substance Inventory Count Sheet education to compete narcotic count at the beginning and end of each shift with all Licensed Nurses and Certified Medication Aides into Orientation process to assure all newly hired and Contracted Licensed Nurses and Certified Medication Aides are educated on completing documented signature on the Shift Change Controlled Substance Inventory Count Sheet at the beginning and the end of each shift. 4. The facility initiated 100% audit regarding completion of signature documentation on the Shift Change Controlled Substance Inventory Count Sheets on 8/9/2023. Audits will continue to be completed twice weekly for twelve weeks, then monthly to make sure facility is obtaining compliance in which will be conducted by the Director of Nursing and/or Administrative Nursing Designee with random audit of the Shift Change Controlled Substance Inventory Count Sheet in the narcotic book to validate the completion of documentation. During the auditing, if it is noted that that the process was not followed, the Licensed Nurse or Certified Medication Aide will be removed from responsibility of Medication Pass. An educational one-to-one education will be conducted by the Director of Nursing, Staff Development Coordinator, and/or Nursing Administrative Designee to assure Licensed Nurse and Certified	

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F 755	Continued From page 3 c. Review of the East Annex #2 medication cart with Nurse #5 revealed the Shift Change Controlled Substance Inventory Count sheet from 6/27/23 7:00 AM - 8/9/23 7:00 AM were missing the following entries: - 18 of 172 controlled substance card counts were not completed - 1 of 86 nurse signatures for "coming on duty" were missing - 6 of 86 nurse's signatures for "going off duty" were missing An interview was conducted on 8/9/23 at 3:26 PM with Nurse #5. She revealed that when she started a shift, she counted all of the controlled substance cards and sheets to make sure they aligned with the departing nurse's information. At the end of her shift, she counted the cards and sheets again with the oncoming nurse. Nurse #5 stated there was never a time when she did not sign the shift change controlled substance inventory count sheet because her signature verified that the count was correct. d. Review of the East Hall #2 medication cart with Nurse #4 revealed the Shift Change Controlled Substance Inventory Count sheet from 7/2/23 7:00 PM - 8/9/23 7:00 AM were missing the following entries: - 5 of 104 controlled substance card counts were not completed - 3 of 52 nurse's signatures for "going off duty" were missing An interview was conducted with Nurse #4 on 8/9/23 at 3:09 PM. Nurse #4 stated the controlled substances were counted when she came in for her shift to make sure the number of sheets and	F 755	Medication Aide are knowledgeable of the process of completing documented signature on the Shift Change Controlled Substance Inventory Count Sheets when reporting on and off. 5. The Administrator will forward the results of the audits from the Director of Nursing of the Shift Change Controlled Substance Inventory Count Sheets to the Executive Quality Assurance and Performance Improvement Committee for review of the Narcotic Reconciliation Protocol Audit monthly times three months. The Executive Quality Assurance and Performance Improvement Committee will determine trends and/or concerns that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Date of Compliance: 9/7/2023	

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F 755	Continued From page 4	F 755		

cards were correct and was the same as the departing nurse. The same process was followed for when she completed a shift as well. Nurse #4 indicated there was never a time that she did not sign it, unless it was incorrect, but she had not yet experienced that. If there was an issue with the inventory sheet, then she would notify the Unit Manager.

The Unit Manager was interviewed on 8/9/23 at 1:58 PM. He revealed that nurses were expected to count off the total number of cards and sheets with a signature when they arrive for their shift and when they finish their shift. If there was not a signature, then nurses were expected to come back to the facility and make sure the shift change inventory sheet was signed. The Unit Manager indicated that the narcotic books were checked by him every 15th day of the month to make sure they were completed correctly. However, he stated he took the Unit Manager position one week ago, and before then, the responsibility was assigned to the Assistant Director of Nursing (ADON) and DON.

A phone interview was conducted with the Pharmacist on 8/9/23 at 2:59 PM. He revealed that he performed random audit narcotic card counts when he was in the building monthly. However, nursing staff were responsible for the day-to-day reconciliation and should be counted at every shift change.

During an interview with the ADON on 8/10/23 at 8:43 AM, she revealed that nurses were expected to count the controlled substance sheets/cards and ensure the narcotic book reconciled with the medication cart at the start and end of each shift. If there was an issue, nursing staff needed to

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F 755	Continued From page 5 make the correction before they left from their shift. The ADON indicated the narcotics book was reviewed on the 15th of each month by the DON or Nurse Manager to make sure that the shift change inventory sheets were signed off properly. If there were any missing entries, then the ADON stated she would find out who was working that shift and have them sign. The DON was interviewed on 8/10/23 at 9:02 AM. She revealed nurses were expected to count and sign the shift change inventory sheet at the beginning and end of every shift. if there was a discrepancy with the shift change inventory sheets, then she should have been notified immediately. The DON stated that she or the Unit Manager monitor and audit the shift change sheets on the 15th of every month. She indicated that the missing entries might have been caused by nursing staff were ready to leave work and perhaps forgot to sign. An interview with the Administrator was conducted on 8/10/23 at 9:20 AM. She revealed the oncoming nurse was expected to count and sign the shift change inventory sheet, as well as the off going nurse. The facility protocol was for the DON or Nurse Manager to monitor the controlled substances form on or before the 15th of every month. The Administrator indicated that education and auditing needed to be put in place.	F 755		
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	F 761		9/7/23

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F 761	Continued From page 6 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure medication storage cabinets in an unlocked room, remove expired medications from storage cabinets and refrigerator, failed to monitor temperatures of a refrigerator storing medication, and failed to secure a medication cart for 2 of 9 storage areas reviewed (Training Room and West Hall medication cart). Findings included: 1. Facility documentation noted two medication storage areas, one on the east annex hall and one on the west hall. The Training Room, used as a conference room, was granted to the state agency for use while on site. It was observed on 8/7/23 at 10:15 AM with a	F 761	1. The facility failed to ensure medications were stored, locked and secured at all times. 2. All residents who receive medication from the medication cart and or medication storage room have potential to be affected. 3. The Director of Nursing initiated 100% education in-service to all Licensed Nurses and Certified Medication Aides on 8/7/2023 regarding assuring all Medication Carts, Treatment Medication Carts, Medication Storage Cabinets. In-service will be completed by 9/7/2023. Any Licensed Nurses and Certified Medication Aides that have not worked	

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F 761	Continued From page 7 bank of cabinets on the walls on the right side of the room. There were 10 cabinet doors, 4 were observed with engaged padlocks and the remaining six without locks. A small refrigerator was observed to the left against the back wall. Daily Training Room remained unlocked while the state agency was on site, On 8/8/23 at 3:21 PM The Assistant Director of Nursing (ADON) was observed in the Training Room and retrieved an item from a padlocked cabinet. She explained overstock of the over-the-counter medications were kept in the Training Room. 1.a. On 8/9/23 at 2:50 PM the Training Room medication storage area was reviewed with the Director of Nursing (DON). The DON explained the Assistant DON (ADON) had the key to the padlocked cabinets. Behind four of the unsecured doors were boxes and bottles of over-the-counter medications. Cabinet #1 contained: 1- Geri-mucil bottle expired 9/22 14- nicotine 7mg transdermal patches 12- nicotine 14 mg transdermal patches 1- tube hemorrhoidal ointment 2 -tubes- triple antibiotic ointment 1- bottle of sodium bicarbonate Cabinet #2 contained: 3- bottles of Prostat 5- bottles nephro vitamins 4- bottles Magnesium 500 mg 5- bottles of Calcium with Vitamin D 600mg/10 mcg 3- bottles of Vitamin D 1250 mcg 1- bottle one-daily multivitamin Cabinet doors #3 and #4 opened into the same cabinet and contained: 8- boxes of ear wax softener drops	F 761	and/or not received education after 9/7/2023 will not be permitted to assume responsibility of Medication Med pass without receiving the aforementioned education from the Director of Nursing, Staff Development Coordinator and/or Nursing Administrative Designee. The facility will also implement education regarding assuring medications are stored, locked, and secured at all times with all Licensed Nurses and Certified Medication Aides into the Orientation process to assure all newly hired and Contracted Licensed Nurses and Certified Medication Aides are educated on assuring medications are stored, locked and secured at all times. 4. The facility initiated 100% audit regarding checking all medication carts, treatments carts and medication storage cabinets to assure stored, locked, and secured at all times. Audits will continue to be completed twice weekly for four weeks, then weekly for four weeks, then monthly times three months to assure facility is obtaining compliance in which will be conducted by the Director of Nursing and/or Administrative Nursing Designee with random audits utilizing the Narcotic Reconciliation Protocol Audit. During the auditing, if it is noted that that the process is not followed, the Licensed Nurse or Certified Medication Aide will be removed from responsibility of Medication Pass. An educational one-to-one education will be conducted by the Director of Nursing, Staff Development Coordinator, and/or Nursing Administrative Designee to assure Licensed Nurse and Certified	

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F 761	Continued From page 8 2- tubes clotrimazole creme 1% 1- mineral oil enema 26- nicotine 14 mg transdermal patches 2- bottles of milk of magnesia 8- bottles of clear-lax An interview with the DON was conducted on 8/9/23 at 3:00 PM. She stated the overstock medications were stored in the Training Room and explained the door to the training room was locked at night and unlocked in the morning because this was the location of the morning stand up meeting. She explained the ADON, or the Central Supply Aide rotated and checked the medications in the cabinets. 1.b. The refrigerator in the Training Room was observed with the Director of Nursing (DON) on 8/10/23 at 3:05 PM. No temperature log was observed. The thermometer in the back of the refrigerator was coated with a black substance and was difficult to read. The refrigerator contained: 1- opened, unmarked multi dose vial of tuberculin purified protein derivative with an expiration date of 9/24. Package instructions noted to store between 38-46 degrees Fahrenheit. 7- influenza vaccine quadrivalent, expiration date 6/30/23 38- influenza vaccine for adults 65 years and older adjuvanted, expiration date 6/14/23 5- Fluad HD PFS 65+ (influenza vaccine), expiration date 5/9/23 1- bottle of flavored water An interview with the DON was conducted on 8/10/23 at 3:15 PM. The DON looked at the thermometer and stated she could not read it as it	F 761	Medication Aide are knowledgeable of the process of assuring medications are stored, locked and secured at all times. 5. The Administrator will forward the results of the audits from the Director of Nursing of the Narcotic Reconciliation Protocol Audit to the Executive Quality Assurance and Performance Improvement Committee for review monthly times three months. The Executive Quality Assurance and Performance Improvement Committee will determine trends and/or concerns that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Date of Compliance: 9/7/2023	

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F 761	Continued From page 9	F 761		

was old and threw it into the trash. After reviewing the medication in the refrigerator, she stated all of the medications were expired, except the tuberculin which had been opened but not marked with a date. She stated she could not be sure of the refrigerator storage temps because there was no temperature log. She stated she thought the refrigerator was for employees to use and had never looked in it.

1.c. On 8/9/23 at 4:16 PM an observation of the 4 padlocked cabinets with the Assistant Director of Nursing (ADON) was conducted. Three of the locked cabinets contained bottles and boxes of medications. One bottle of sodium chloride 1 gram tablets with an expiration date of 1/23 was discovered. The fourth padlocked cabinet was empty.

On 8/9/23 at 4:17 PM an interview with the Assistant Director of Nursing (ADON) was conducted. She explained overstock medications were kept in the Training Room. The newer medications were put in the back and the items more likely to expire sooner were moved toward the front of the cabinets. She stated she would expect the medications to be discarded when they expired.

2. On 8/9/23 at 11:09 AM the West Hall medication cart was observed parked alongside the nurses' desk with keys hanging from its protruding, disengaged lock. The lock, when engaged is nearly flush with the cart. There were no residents present in the immediate area.

On 8/9/23 at 11:10 AM Nurse #6 walked up to the medication cart. When asked about the keys hanging from the lock, she explained the

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F 761	Continued From page 10 medication cart should be secured when the nurse was not in attendance. On 8/09/23 at 11:13 AM an interview with Nurse #1 was conducted. She explained she did not know why she left the keys in the medication cart's lock unattended. She stated the cart should have been secured when she walked away. On 8/10/23 at 10:33 AM The Administrator and ADON were interviewed. The Administrator stated medications should be secured under lock and key and explained medication refrigerators should be monitored but the refrigerator in the Training Room was for staff use.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		9/7/23

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F 867	Continued From page 11 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 12 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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F 867	Continued From page 13 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews, and pharmacy interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 12/17/20 complaint investigation survey and 2/4/22 recertification survey. The facility had deficiencies previously cited in the areas of pharmacy services/procedures/pharmacist/records (F755) and label/store drugs and biologicals (F761). F761 was cited on 12/17/20 during a complaint investigation survey and on 2/4/22 during a recertification survey and F755 was cited on 2/4/2022 during a recertification survey. These deficiencies were cited again during the facility's current recertification and complaint investigation survey of 8/10/23. The continued failure of the facility during 3 federal surveys shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to:	F 867	1. August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). 2. Residents residing in the facility have the potential to be affected. 3. On 8/11/2023 the Regional Vice President of Clinical Services provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 8/11/2023, under the direction and supervision of the Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS Licensed Nurse, Maintenance Director,	

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F 867	Continued From page 14 1. F755: Based on record review, staff and pharmacy interviews, the facility failed to complete the shift change inventory sheet consistently and accurately for 4 of 7 medication carts reviewed. During the facility's recertification survey on 2/4/22 the facility failed to acquire prescribed medication for administration resulting in failure to administer a medication as ordered by the physician for 1 of 10 residents whose medications were reviewed. An interview was completed on 8/10/23 at 12:00pm with the Administrator. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The Administrator indicated there were no current monitoring plans in place for label/store drugs and biologicals and pharmacy services/procedures/pharmacist/records. The Administrator indicated it was her expectation the facility continued to follow the QAA process and monitor those issues within the facility so they would not receive a recited deficiency. 2. F761: Based on observations and staff interviews, the facility failed to secure medication storage cabinets in an unlocked room, remove expired medications from storage cabinets and refrigerator, failed to monitor temperatures of a refrigerator storing medication, and failed to secure a medication cart for 2 of 9 storage areas reviewed (Training Room and West Hall medication cart). During the facility's complaint survey on 12/17/20 the facility failed to safeguard the medications of	F 867	Social Service Director and Social Service Assistant, Business Office Manager, Therapy Director, Admission Director, Dietary Manager, Scheduler/Central Supply, Transport, Medical Records, Activity Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. 4. The QAPI Committee will meet weekly for four weeks starting on 9/7/23, then monthly until substantial compliance is obtained, to monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits / reports. An Ad Hoc QAPI meeting was held on 8/22/2023, to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS Licensed Nurse, Maintenance Director, Social Service Director and Social Service Assistant, Business Office Manager, Therapy Director, Admission Director, Dietary Manager, Scheduler/Central Supply, Transport, Medical Records, Activity Director. 5. The Administrator is responsible for ensuring this plan of correction is implemented. The Executive Quality Assurance and Performance Improvement Committee will determine trends and/or concerns that may need	

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F 867	Continued From page 15 deceased residents on the Covid-19 unit by keeping them locked and only accessible to appropriate personnel. (a number of residents was not specified) During the facility's recertification on 2/4/22 the facility failed to monitor temperatures for 1 of 1 medication refrigerators (main medication room refrigerator), the facility failed to discard expired medications for 3 of 3 medication carts (West Hall, South Hall, and East Annex Cart 2) and failed to date opened medication for 1 of 3 medication carts. The facility also failed to ensure the medication cart was secured while unattended for 1 or 3 medication carts (East Annex Cart 1). An interview was completed on 8/10/23 at 12:00pm with the Administrator. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The Administrator indicated there were no current monitoring plans in place for label/store drugs and biologicals and pharmacy services/procedures/pharmacist/records. The Administrator indicated it was her expectation the facility continued to follow the QAA process and monitor those issues within the facilit so they would not receive a recited deficiency.	F 867	further interventions put into place and to determine the need for further and/or frequency of monitoring. 6. Compliance Date: 9/7/2023	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		9/7/23

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F 883	Continued From page 16	F 883		

each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the

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F 883	Continued From page 17 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the pneumococcal vaccinations upon admittance into the facility (Resident #66, Resident #80, Resident #94) and offer annual influenza vaccine (Resident #66) for 3 of 5 residents reviewed for immunizations. The findings included: The facility policy for Pneumococcal Vaccine dated 2/2/2022 read in part "It is the policy of the facility that all residents be provided the opportunity and encouraged to receive pneumococcal vaccinations. Upon admission, obtain consent and acknowledgement for administering the pneumococcal vaccination from resident and/or resident's representative party. If vaccination was previously obtained within the past 5 years, it will be recorded on the immunization record." The facility policy for Influenza Vaccine dated 2/2/2022 read in part "All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually." It further read "between October 1st and March 31st of each year, the influenza vaccine shall be offered	F 883	1. The facility failed to obtain the consent or declination for receival of the Influenza and Pneumococcal vaccinations. 2. All residents who consent to receive the Influenza or Pneumococcal vaccination have potential to be affected. 3. The Administrator completed education with the Director of Nursing and Assistant Director of Nursing regarding obtaining consent and/or declination of the Influenza and Pneumococcal vaccination on 8/11/2023. 4. The Director of Nursing and/or Designee initiated 100% audit on 8/22/2023 to identify all residents who are eligible to obtain a consent or declination form of the Influenza and Pneumococcal vaccination. This audit will be completed by 9/7/2023. The Director of Nursing and/or Designee will assure facility is in compliance in offering vaccinations by obtaining an consent or declination form for Influenza and Pneumococcal on a weekly basis for twelve weeks an ongoing beginning on 8/22/2023. 5. The Administrator will forward the results of the audits from the Director of	

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F 883	Continued From page 18 to residents unless the resident has already been immunized." a. Resident #66 was admitted to the facility on 1/17/23 with diagnoses that included diabetes and high cholesterol. The Quarterly Minimum Data Set (MDS) assessment dated 5/15/23 revealed the Resident was cognitively intact and coded as not receiving the influenza or pneumococcal vaccine. Review of Resident #66's immunization record revealed no documentation that her or her responsible party had been offered, given, or refused the pneumococcal or influenza vaccine. b. Resident #80 was admitted to the facility on 3/21/23 with diagnoses that included heart failure, high blood pressure, and diabetes. The Quarterly MDS dated 6/26/23 revealed Resident #80 was cognitively impaired and coded as not receiving the pneumococcal vaccine. Review of the Resident's immunization record reveals no documentation that her or her responsible party had been offered, given, or refused the vaccine. c. Resident #94 was admitted to the facility on 10/27/22 with diagnoses that included hypertension and muscle weakness. The Quarterly MDS dated 7/3/23 revealed that the Resident was cognitively intact and coded as not receiving the pneumococcal vaccine. Review of the Resident's immunization record	F 883	Nursing of the Influenza and Pneumococcal Audit to the Executive Quality Assurance and Performance Improvement Committee for review monthly times three months. The Executive Quality Assurance and Performance Improvement Committee will determine trends and/or concerns that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. 6. Date: 9/7/2023	

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reveals no documentation that her or her responsible party had been offered, given, or refused the vaccine.

An interview was completed on 8/10/23 at 8:42am with Director of Nursing (DON) who was also the Infection Preventionist. The DON revealed she was new to the position and facility. The DON indicated when a new admission arrived at the facility, she reviewed the hospital discharge record for administered vaccines and interviewed the resident and responsible party and recorded the vaccinations in the resident's immunization record. The DON revealed she was unsure why vaccinations had not been offered to facility residents and was currently in the process of completing vaccinations.

An interview was completed on 8/10/23 at 10:58am with the Administrator. She indicated the Infection Preventionist was new to her role and was working with the Assistant Director of Nursing to complete resident vaccinations.