STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 unnanounced recertification and complaint investigation survey was conducted on 7/23/2023 through 7/26/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BWVM11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/23/23 through 7/26/23. Event ID# BWVM11. The following intakes were investigated NC00199437 and NC00192559. 11 of the 11 complaint allegations did not result in a 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 (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		7/26/23

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

Electronically Signed | 08/24/2023

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F 623	Continued From page 1	F 623		

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;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 2 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 record review, resident interview, Ombudsman interview and staff interview, the facility failed to provide written notice of discharge for residents who were transferred to the hospital to the resident or the resident's representative	F 623	For Resident #1 and #65, the residents have since returned to the facility and if they have to go back out to the hospital a transfer notice will be issued at that time and given to the Ombudsman as well. The	

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F 623	Continued From page 3 and the ombudsman for 2 of 3 residents reviewed for hospitalization (Resident #65 and Resident #1). Findings included: 1. Resident #65 was admitted to the facility on 2/7/2022. Nursing documentation dated 4/2/23 recorded a physician order was received to transfer Resident #65 to the hospital after receiving a right hip x-ray report, and Resident #65 was transferred to the local hospital for evaluation and treatment. The significant change Minimum Data Set (MDS) assessment dated 6/16/2023 indicated Resident #65 was cognitively intact. There was no written notice of transfer located in Resident #65's medical record. In an interview with Resident #65 on 7/25/2023 at 9:12 a.m., she stated she was transferred to the hospital on 4/2/2023 to have surgery because an x-ray the facility ordered showed a fractured hip. Resident #65 did not recall receiving a written notice of discharge from the facility. In an interview with the Admission Director on 7/25/2023 at 3:49 p.m., she stated nursing was responsible for notifying residents or resident representative and providing a written notice for the reason a resident was transferred from the facility. In an interview with Nurse #1 on 7/25/2023 at 4:24 p.m., she stated written notice of transfers was handled by the administrative staff, and	F 623	Administrator/Designee will send a Transfer Notice as soon as practicable to the Responsible Family Member or Resident as well as email a copy of the transfer notice to the Ombudsman. A copy of the Transfer Notice will then be placed on the Resident's Medical Record on Point Click Care. For those residents having the potential to be affected, the Nursing staff will continue calling and documenting the call to the Responsible Party concerning a discharge. When residents are discharged from the facility to the hospital, the facility will send a Transfer Notice as soon as practicable to the Responsible Family Member or Resident as well as email a copy of the transfer notice to the Ombudsman. A copy of the Transfer Notice will then be placed on the Resident's Medical Record on Point Click Care. The Social Services Director was educated on the Transfer Notice on 7/26/23 by the Administrator. The Administrator and/or her designee will send the Transfer Notice as soon as practicable to the Responsible Family Member or Resident as well as email a copy of the transfer notice to the Ombudsman. A copy of the Transfer Notice will then be placed on the Resident's Medical Record on Point Click Care. The Social Services Director will audit Point Click Care for continued compliance	

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F 623	Continued From page 4 nursing staff did not complete a written notice of transfers when transferring residents from the facility. In an interview with the Director of Nursing on 7/26/2023 at 9:00 a.m., she stated the facility did not have a written notice of discharge form that the nursing staff was responsible for sending to the resident or the resident representative when residents were transferred or discharged from the facility. She explained the Social Worker sent 30-day discharge notices to the Ombudsman but was unsure if the Social Worker notified the Ombudsman of all transfers and discharges. She stated she was not aware of the regulation that the facility was required to send a written notice of discharge to Resident #65 or Resident #65's representative. In an interview with the Social Worker on 7/26/2023 at 9:01 a.m., she stated she was not aware of a written notice of discharge form that the facility sent to the residents or resident representatives. She stated she notified the Ombudsman of 30-day notices of discharge and did not communicate transfers to the hospital to the Ombudsman. In a phone interview with the facility's assigned Ombudsman on 7/26/2023 at 9:19 a.m., she explained she had communicated with the facility in a mass email greater than three months ago to complete the Center of Medicare and Medicaid notice of discharge form for transfers and discharges to communicate reason resident was discharged from the facility to the Ombudsman. She stated the facility was sending a list of discharges and transfers from the facility indicating where the resident went monthly, but	F 623	and take the audit results to the monthly Quality Assurance Committee for three (3) months to ensure continued compliance.	

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F 623	Continued From page 5	F 623		

she had not received written discharge notices that informed the Ombudsman why the resident was transferred or discharged.

In an interview with the Administrator on 7/26/2023 at 9:34 a.m., she stated at the first of the month she sent the Ombudsman a list of the residents transferred and discharged from the facility. She explained 30-day notice of discharges were sent immediately to the Ombudsman. The Administrator stated she did not recall the Ombudsman indicating she needed a written notice of discharge as to why the resident was discharged or transferred from the facility and had not sent a written notice of discharge to the Ombudsman, Resident #65 or Resident #65 Resident Representative.

2. Resident #1 was admitted to the facility on 5/31/2015 with a re-entry from a hospital on 7/17/23.

Review of the comprehensive Minimum Data Set (MDS) dated 5/6/23 showed Resident #1 was moderately cognitively impaired.

Progress note dated 7/14/23 and written by Nurse #3 read in part "sent to emergency room for evaluation of left sided numbness and elevated blood pressure."

Review of Resident #1's medical record showed no written notice of transfer.

An interview was attempted with Resident #1 on 7/26/23 at 9:05 A.M. and 7/26/23 at 2:00 P.M. Both attempts were unsuccessful.

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F 623	Continued From page 6 An interview was attempted on 7/26/23 at 12:02 P.M. with Nurse #3 who was assigned Resident #1 on 7/14/23. The interview was unsuccessful. An interview was conducted on 7/25/23 at 3:49 P.M. with the Admission Director. During the interview, the Admission Director stated nursing was responsible for notifying residents or resident representative and providing a written notice for the reason a resident was transferred from the facility. An interview was conducted on 7/26/23 at 9:00 A.M. with the Director of Nursing (DON). During the interview, the DON stated the facility did not have a written notice of discharge form that the nursing staff was responsible for sending to the resident or the resident representative when residents were transferred or discharged from the facility. The DON further explained, she was not aware of the regulation that the facility was required to send a written notice of discharge to a resident who was transferred or discharged from the facility.	F 623		
F 641 SS=E	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 interview the facility failed to accurately code the Minimum Data Set (MDS) assessment for behaviors (Resident #3), anticoagulant use (Resident #12 and #8) and developmental disability (Resident	F 641	The MDS for Resident #3 was corrected and resubmitted on 8-22-23 to reflect behaviors for 4/21/26 and 4/25/26. The Restorative Aide will notify the Social Worker any time that a resident refuses	8/22/23

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F 641	Continued From page 7 #72) for 4 of 23 residents whose MDS assessments were reviewed. Findings included: 1. Resident #3 was admitted to the facility on 3/30/18 with diagnoses that included heart failure and hypertension. A progress note dated 4/21/23 indicated Resident #3 had refused to participate in transfers. Review of a progress note dated 4/25/23 revealed Resident #3 refused to participate in assisted range of motions and transfers. Resident #3's Minimum Data Set (MDS) assessment dated 4/27/23, a quarterly assessment revealed she was cognitively intact with no behaviors. An interview was conducted with the facility social worker on 7/25/23 at 2:30 PM who stated she was responsible for the behavior section of the MDS assessment. She reported she had not seen the progress notes dated 4/21/23 and 4/25/23 and therefore did not code Resident #3 for rejection of care. During an interview with the Administrator on 7/25/23 at 2:31 PM she stated Resident #3's MDS assessment should have reflected her behavior. She reported the facility social worker had been out of the office so that may have been the reason for the error. 2. Resident #12 was admitted to the facility on 9/17/2015, and diagnoses included stroke.	F 641	restorative services using a communication form to enable the Social Services Director to identify behaviors. No other resident were identified as having refused restorative care. The Restorative Aide will notify the Social Worker any time that a resident refuses restorative services using a communication form to enable the Social Services Director to identify behaviors. The restorative refusal forms will be given to the MDS Coordinator by the Social Services Director to follow-up and audit behaviors. Audit findings will be reported to QAPI committee and Regional MDS Consultant monthly x3 months or until substantial compliance is determined by no newly identified missed behavior assessments noted for 3 consecutive months. The assessments for residents identified to be in error (#12, #8, #72) were corrected and resubmitted on 8/22/23. All residents were identified to have the potential to be affected. On 8/22/23 an audit was completed by the MDS coordinator on all current residents receiving aspirin and no further anticoagulant coding errors were noted. MDS assessments will be audited weekly upon completion for accuracy in coding by the MDS coordinator and all results submitted to the Regional MDS	

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F 641	Continued From page 8 Physician orders indicated on 9/27/2019, Resident #12 was ordered Aspirin 81 milligrams daily for pain with instructions to hold for vaginal bleeding. There was no order for an anticoagulant located in the physician's orders for Resident #12. The quarterly Minimum Data set (MDS) assessment dated 4/18/2023 indicated Resident #12 was severely cognitively impaired and had received an anticoagulant daily for the 7-day look back period. A review of the April 2023 Medication Administration Record (MAR) indicated Resident #12 received Aspirin 81 milligrams daily from April 1, 2023, to April 30, 2023. In an interview with MDS Nurse #1 on 7/25/2023 at 3:16 p.m., she stated Resident #12 received Aspirin daily, and Resident #12's MDS was coded for use of an anticoagulant. She explained Aspirin was a blood thinner and not an anticoagulant, and she had coded the Aspirin incorrectly. In an interview with the MDS Coordinator on 7/25/2023 at 3:24 p.m., she explained since the departure of a former MDS employee in April 2023, the MDS office had been in a transition period. She stated she monitored the completion of each section including the medications and must have overlooked Resident #12 coded for use of anticoagulants when receiving Aspirin. In an interview with the Administrator on 7/26/2023 at 6:02 p.m., she explained since the change in MDS staff in April 2023, the facility had not had a MDS consultant come to the facility to monitor MDS assessments and the facility had not conducted any monitoring for accuracy of	F 641	Consultant and the QAPI committee. Any coding errors noted will be corrected immediately and the staff member re-educated on MDS coding policy. Audit findings will be reported to QAPI committee and Regional MDS Consultant monthly x3 months or until substantial compliance is determined by no newly identified coding errors noted for 3 consecutive months.	

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F 641	Continued From page 9	F 641		

MDS assessments. She stated MDS assessments should be completed accurately, and Aspirin should not had been coded as an anticoagulant.

3. Resident #8 was admitted to the facility on 8/1/2020, and diagnoses included dementia.

Physician orders dated 4/28/2023 included Resident #12 receiving Aspirin 81 milligrams every day for cardiology protection. There was no order for an anticoagulant located in the physician's orders For Resident #8.

The quarterly Minimum Data Set (MDS) assessment dated 5/26/2023 indicated Resident #8 was severely cognitively impaired and had received an anticoagulant daily for the seven-day look back period.

A review of the May 2023 Medication Administration Record (MAR) indicated Resident #8 was administered Aspirin 81 milligrams daily from May 1, 2023 to May 31, 2023.

In an interview with MDS Nurse #1 on 7/25/2023 at 3:21 p.m., she stated after reviewing Resident #8's MDS for use of medications, Resident #8 was incorrectly coded for anticoagulants. She explained Aspirin was a blood thinner and not an anticoagulant, and the MDS would need to be corrected.

In an interview with the MDS Coordinator on 7/25/2023 at 3:24 p.m., she stated she checked MDS assessments for completion and must had overlooked Resident #8's coding for anticoagulants when receiving Aspirin daily.

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F 641	Continued From page 10 In an interview with the Administrator on 7/26/2023 at 6:02 p.m., she stated MDS assessments were to be accurate and Resident #8 receiving Aspirin daily should not had been coded as an anticoagulant on the MDS assessment. 4. Resident #72 was admitted to the facility on 5/8/2023. Psychiatric documentation dated 5/10/2023 recorded Resident #72 was diagnosed between 20-30 years old as developmentally delayed. The admission Minimum Data Set (MDS) assessment dated 5/15/2023 indicated Resident #72 was severely cognitively impaired. Resident #56's MDS was not coded for an developmental disability. In an interview with MDS Coordinator on 5/25/2023 at 3:27 p.m., she explained the reason Resident #72's MDS was not coded for an developmental disability. She explained she was not aware of Resident #72's diagnoses for developmental disabilities that required coding. In an interview with the Administrator on 7/26/2023 at 5:58 p.m., she stated since the change in MDS staff in April 2023, there had been no monitoring for accuracy of the MDS assessments. She stated Resident #72's MDS assessment should have been coded for a developmental disability.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		8/24/23

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F 644	Continued From page 11 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 staff interview and record review the facility failed to refer residents with a newly identified serious mental health diagnosis for a level II Pre-Admission Screening Resident Review (PASRR) for 2 of 6 residents reviewed for PASSR (Resident #49 and Resident #56). The findings included: 1. Resident #49 was admitted to the facility on 6/12/20. Review of Resident #49's diagnoses revealed she was diagnosed with schizoaffective disorder 1/31/22. Review of Resident #49's record revealed no evidence of a screening for a level II PASSR.	F 644	The Social Services Director completed a Level II PASSR for residents #49 and #56 on 7/26/23 and received the Approved PASSR Level II on 7/31/23 and #56 was completed on 7/25/23 and received the approved PASSR Level II on 7/28/23. All residents with a serious mental health diagnosis have been identified to have the potential to be affected. The Social Services Director has audited the resident charts between 7/26/23 and 8/24/23 and has identified additional Level II PASSR needs. Those residents identified as having a need for a PASSR Level II are currently in the process of having a PASSR Level II completed. The Social Services Director was	

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MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

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F 644	Continued From page 12 An interview with Social Worker #1 on 7/25/23 at 10:08 AM was conducted. She stated she was not aware a level II PASSR screening should be done when a resident received a new diagnosis such as schizoaffective disorder or bipolar disorder. An interview was conducted with the Administrator on 7/25/23 at 2:48 PM and she stated she was not aware of the level II PASSR process She reported if the facility had known a referral for a level II PASSR screening was required for a newly identifid serious mental health diagnosis then it would have been requested for Resident #49. 2. Resident #56 was admitted to the facility on 10/30/2021. A review of Resident #56's diagnoses indicated bipolar disorder was added on dated 9/1/2022. The annual Minimum Data Set (MDS) assessment dated 10/4/2022 indicated Resident #56 was cognitively intact and diagnoses included bipolar disorder. The MDS further indicated for the 7-day look back period Resident #56 had received antianxiety and antidepression medication daily. Psychiatric progress notes indicated Resident #56 was followed by psychotherapy every two weeks and revealed, in part, the following: -12/19/22 Resident #56's mood was calm to frustrated based on subject content. -1/4/2023 recorded Resident #56's bipolar disorder was in partial remission with most recent episode of depression. Resident #56 received	F 644	educated on 7/26/23 concerning diagnosis that would require a level II PASSR by Karen Williams, Director of Policy and Procedures for the NC MUST Program. The Social Services Director will audit charts upon admission for a serious mental heath diagnosis that would require a Level II PASSR and will review current resident's orders daily for any changes in conditions related to a serious mental health diagnosis and will initiate a Level II PASSR if a serious mental health diagnosis is identified as well as alerting the MDS Nurse of a diagnosis needed for the resident assessment. PASSR level changes will be reported to the QAPI Committee and Regional MDS Consultant monthly x 3 months or until substantial compliance is determined.	

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F 644	Continued From page 13	F 644		

Lithium, a mood stabilizer, 300 milligrams at bedtime for the bipolar disorder and Valium, a sedative, 5 milligrams at night for anxiety disorder.
-6/28/2023 recorded Resident #56 having panic attacks due to worrying about her health and memories of past trauma that frequently occurred at night. Lithium 300 milligrams was continued and Valium was decreased to 2 milligrams at bedtime.

There was no documentation of a Level II Pre-Admission Screening and Resident Review (PASRR) in Resident #56's medical record.

In an interview with the Social Worker #1 on 7/25/2023 at 10:08 a.m., she stated Resident #56's Level I PASRR screening was completed at the hospital prior to admission to the facility. She stated she did not know she was to submit a referral for a Level II PASRR screening for Resident #56 due to her having a newly evident diagnosis of a bipolar disorder. She reported a psychiatric physician monitored and ordered medications for Resident #56's bipolar disorder, and a change in PASRR had not been submitted for Resident #56. In a follow up interview on 7/25/2023 at 2:27 p.m., the Social Worker reported she had spoken to a representative in PASRR Policy and Procedures via phone and was informed residents with bipolar disorders required a referral for a Level II PASRR screening and would be submitting a referral for a Level II PASRR for Resident #56.

In an interview with the Administrator on 7/25/2023 at 12:19 p.m. she explained the Social Worker reviewed the diagnoses of residents when admitted for PASRR and thought a Level II

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F 644	Continued From page 14 PASRR screening was needed if there was a change in condition and lifestyle of the resident. In a follow up interview on 7/25/2023 at 2:48 p.m., she stated she was not aware of the referral for a Level II PASRR screening procedure for residents with newly evident mental health diagnoses. She explained if the facility had known a referral for level II PASSR screening was required for Resident #56's diagnoses of bipolar disorder, a Level II PASRR screening would have been submitted.	F 644		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		7/26/23

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F 732	Continued From page 15 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post daily staffing census for 1 of 4 days during the recertification and complaint investigation survey. Findings included: On 7/23/2023 at 10:30 a.m. upon entrance into the facility, there was no daily staffing census posted in the facility. On 7/23/2023 at 12:30 p.m., a daily staffing census post was not located in the facility. In an interview with the Director of Nursing (DON) on 7/23/2023 at 12:56p.m. when the DON was asked where the facility displayed the daily staffing census, she stated the daily staffing census was posted on a bulletin board in the hallway outside the dining area. The bulletin board was observed empty with no information or daily staffing census posted. The DON stated the Staff Development Coordinator (SDC) was responsible for posting the daily staffing census prior to leaving on Fridays for the weekend. She	F 732	The Daily Nurse Staffing Data sheet was posted at approximately 1:00 pm on Sunday July, 23, 2023. The Staff Development Coordinator and weekend supervisor was educated by the Director Of Nursing Services on 7/23/23. The Staff Development Coordinator will be responsible for ensuring that the Nurse Staffing Data is posted daily, and the weekend supervisor is responsible for posting Daily Nurse Staffing sheets on the weekends. The Director of Nursing Services will monitor that the Nurse Staffing Data is posted daily Monday thru Friday and the weekend supervisor will monitor on Saturday and Sunday. To prevent other residents from being affected, The Staff Development Coordinator will be responsible for ensuring that the Nurse Staffing Data is posted daily, and the weekend supervisor is responsible for posting Daily Nurse Staffing sheets on the weekends. The Nurse Staffing Data will be completed by	

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F 732	Continued From page 16 said the supervisor of weekends made note of staffing changes as needed on the schedule. In an interview with the SDC on 7/26/2023 at 3:50 p.m., she explained the reason why the daily staffing census was not posted on 7/23/2023 was because the new scheduler, who was in training, did not print and post the daily staff census sheets for the weekend of 7/23202. The scheduler was not available for an interview on 7/26/2023. In an interview with the Administrator on 7/26/2023 at 5:51 p.m., she stated the SDC prepared daily staffing census sheets on Friday for the weekend, and she should had posted the daily staffing sheet for 7/23/2023 prior to leaving for vacation. She stated the weekend nursing staff were not aware to post daily staffing census, but the facility recently hired a weekend nursing supervisor who would be trained and responsible for posting the daily staffing census on the weekends going forward.	F 732	the Staff Development Coordinator and left for the weekend supervisor to place on the bulletin board for weekends. The Director of Nursing Services will monitor that the Nurse Staffing Data is posted daily Monday thru Friday and the weekend supervisor will monitor on Saturday and Sunday. The Director of Nursing Services will monitor that the Nurse Staffing Data is posted daily Monday thru Friday and the weekend supervisor will monitor on Saturday and Sunday. Results of monitoring will be brought to the monthly QA Meeting for review x 3 months or until substantial compliance is identified.	
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		8/14/23

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F 761	Continued From page 17 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, record review, and staff interviews, the facility failed to maintain a medication storage refrigerator within the recommended temperature range for 1 of 2 medication storage refrigerators reviewed (South Medication Storage Room). Findings included: An observation of the South Medication Storage Room was made on 7/26/23 at 10:15 AM with the Director of Nursing (DON). The refrigerator thermometer was observed at 34 degrees Fahrenheit (F). The DON viewed the refrigerator thermometer and indicated it appeared to read 34 F. The July 2023 temperature monitoring log for the medication storage refrigerator showed temperatures had been documented daily and ranged between 30-36 degrees F. Temperatures were recorded at 30 degrees F on 2 of 25 days (7/18/23 and 7/19/23), 32 degrees F on 14 of 25	F 761	The Director of Nursing Services adjusted the refrigerator temperature on 7/26/23 to the manufacturers package instructions to store unopened insulin at 36-46 degrees F. All residents were identified to have the potential to be affected. The Director of Nursing Services adjusted the temperature on 7/26/23 to the manufacturers package instructions to store unopened insulin at 36-46 degrees F. A new temperature monitoring form was put into place in the medication rooms to reflect an appropriate temperature range of 36-46 degrees F on 8/14/23. The Director of Nursing will monitor the refrigerators for temperature accuracy and the weekend supervisor will monitor on the weekends for accuracy.	

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F 761	Continued From page 18 days (7/1/23, 7/2/23, 7/3/23, 7/5/23, 7/7/23, 7/8/23, 7/12/23, 7/14/23, 7/15/23, 7/16/23, 7/17/23, 7/20/23, 7/22/23,and 7/25/23), temperature of 33 degrees F on 1 of 25 days (7/23/23), temperature of 34 degrees F on 7 of 25 days (7/4/23, 7/6/23, 7/9/23, 7/10/23 , 7/11/23, 7/13/23 , and 7/21/23), and temperature of 36 degrees F on 1 of 25 days (7/24/23). Above the temperature column read "Fridge Temp 40F or below." The refrigerator contained: - 2- lantanoprost ophthalmic solution 0.005% (used to treat increased eye pressure) with package instructions to store unopened bottle at refrigerator temperatures at 36-46 degrees F. - 3- insulin detemir 100-unit vials with package instructions store at 36-46 degrees F, do not freeze - 9- insulin aspart 100-unit vial with package instructions to store at 36-46 degrees F until first dose - 3- insulin lispro 100-unit vials with package instructions do not freeze - 11- insulin lispro 100-unit injectable pen with no storage instructions - 1 insulin glargine 100-unit vial with package instructions store at 36-46 degrees F, do not freeze. - 8- insulin glargine 100-unit injectable pen with no storage instructions on the pen - 12- dulaglutide injectable pen (used to improve blood sugar levels) with package instructions to store unopened pens at 36-46 degrees F. An interview was conducted on 7/25/23 at 10:20 AM with the DON. During the interview, the DON stated the night shift completed the refrigerator temperature log during their shift and the	F 761	Monitoring will be completed daily x 3 months and monthly thereafter by the Director of Nursing with the results being reviewed at the monthly QA Meeting each month and included in the QAPI minutes.	

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F 761	Continued From page 19 following morning she confirmed the log had been completed. The DON explained the log located on the refrigerator read fridge temp 40 degrees or below and she thought if the refrigerator was 40 degrees or lower, the temperature for the medication storage refrigerator was within the correct range. The DON indicated she had not looked at the manufacturer's storage instructions on the medications located in the refrigerator and was unaware the medication had not been stored as recommended by the manufacturer.	F 761		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly contain refuse and keep the dumpster area free from trash and debris for 3 of 3 dumpsters. Findings included: On 7/24/23 at 11:25 AM an observation was conducted of the facility dumpsters. 11 plastic gloves were observed on the ground surrounding the dumpsters and 4 of 6 side doors on the dumpsters were seen to be open and with a trash bag sticking out of one side door. An observation and interview were conducted with the Dietary Manager (DM) on 7/25/23 at 08:50 AM. During this observation 5 of 6 side doors on dumpster were observed to be open with 11 plastic gloves 3 plastic straws observed on the ground surrounding the dumpsters. The	F 814	The dumpster doors were immediately closed and the gloves on the ground were removed on 7/24/23. A in-service will be provided completed by 8/31/23 to the staff concerning the dumpster doors remaining closed and garbage being thrown on the grounds by the Staff Development Coordinator. The in-service training will be completed by 8/31/23. The Dietary Manager or designee along with the Maintenance Department will be responsible for monitoring the dumpsters to ensure they remain closed and no garbage is on the ground. The Dietary Manager/designee or Maintenance Staff will notify the	8/24/23

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F 814	Continued From page 20 DM stated that doors are supposed to be closed and that waste surrounding bins should be picked up, and added her expectation was there to be no trash on the ground outside the dumpsters. She stated it was the responsibility of the maintenance department to ensure the doors to the dumpsters were closed and no trash was on the ground. In an interview with the Maintenance Director on 07/25/23 at 09:43 he stated the facility had a continual problem with the dumpster doors being left open. He revealed he had spoken with the Director of Nursing in the past about staff leaving the doors to the dumpsters open and trash on the ground and explained his expectation was that the doors to the dumpster be closed and garbage picked up. On 7/25/23 at 4:13 PM an interview was completed with the Director of Nursing (DON). The DON revealed an inservice training about proper waste disposal was conducted on 6/14/23. In an interview with the Administrator on 7/26/23 11:38 AM she stated there had been an ongoing concern about staff members leaving the doors open on the dumpsters. Has been ongoing concern. The Administrator stated her expectation was that the doors on the dumpster be closed and that there would be no garbage on the ground. She explained the responsibility of dumpster maintenance fell under the dietary department. The administrator stated the status of the dumpster should be monitored every morning by the dietary department and that the maintenance department should monitor them throughout the day.	F 814	Administrator if the dumpster doors are found to be open or garbage is found to be on the grounds. The Administrator will notify the proper department and that department employees will be educated. A monitoring tool has been put in place for the Dietary Manager/designee to complete and the monitoring tool will be brought to the monthly QA Meeting for three (3) months or until substantial compliance is determined.	