STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345397	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472

(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 10/16/23 through 10/19/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # KW1K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/16/23 through 10/19/23. Event ID #KW1K11. The following intake was investigated: NC 00208346. 1of the 1 complaint allegations did not result in a deficiency. The Statement of Deficiencies was amended on 10/31/23 at tag F641.	F 000		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		11/6/23

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

Electronically Signed | 11/06/2023

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 636	Continued From page 1	F 636		

(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization

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F 636	Continued From page 2 or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 3 of 20 residents reviewed for MDS assessments (Resident #47, Resident #46, Resident #4). Findings included: a. Resident #47 was admitted to the facility on 8/19/21 with diagnoses which included in part diabetes and chronic kidney disease. Review of Resident #47's 9/28/23 annual assessment revealed a completion date of 10/13/23. b. Resident #46 was admitted to the facility on 3/4/21 with diagnoses which included in part diabetes and dementia. Review of Resident #46's 9/14/23 Significant Change Minimum Data Set (MDS) assessment revealed a completion date of 9/29/23. c. Resident #4 was admitted to the facility on 8/27/23 with diagnoses which included in part diabetes and Alzheimer's dementia. Review of Resident #4's 9/15/23 Significant Change MDS assessment revealed a completion date of 10/2/23. Interview on 10/18/23 at 4:50 PM with the MDS Nurse revealed there were different people completing MDS assessments including some	F 636	The statements made on this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F636 – Comprehensive Assessment and Timing Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required 14 day timeframe was completed as follows: • Resident #47 was admitted to the facility on 8/19/2021. Annual Minimum data set assessment with Assessment Reference Date of 9/28/2023 was completed on 10/13/2023. Assessment was accepted in the state database 10/19/2023 Minimum data set Batch #1896. • Resident #46 was admitted to the facility on 3/4/2021. Significant Change Minimum data set assessment with Assessment Reference Date of 9/14/2023 was completed on 9/29/2023.	

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F 636	Continued From page 3 who worked remotely. The MDS Nurse stated she was aware of the timing of the MDS assessments and that MDS assessments were to be completed per the Resident Assessment Instrument (RAI) manual. The MDS Nurse stated she did not know why some of the assessments were completed late. A follow up interview with the MDS Nurse on 10/19/23 at 10:30 AM revealed she was aware the assessments were not completed during the 14-day allotted time from the Assessment Reference Date (ARD) date established. The MDS Nurse stated corporate nurses were helping her complete assessments remotely. The MDS Nurse indicated she was assigned to work as a staff nurse when needed and was on call every third week of the month for the entire week. During the week on call she worked the floor or completed other tasks if needed. The MDS Nurse further stated she had a high volume of admissions and discharges, and this made it difficult to complete the assessments within the required timeframes. The MDS Nurse stated there were other nurses that worked remotely to assist with completing assessments. Interview with the Administrator and the Corporate Nurse Consultant on 10/19/23 at 5:10 PM revealed they were aware of the situation with the MDS assessments not completed within the regulatory timeframe and the corporate nurses assisted the MDS Nurse with completion of the assessments. The Administrator stated the facility was implementing new procedures to check the timeliness of assessments and hoped to see improvement.	F 636	Assessment was accepted in the state database 10/2/2023 Minimum data set batch #1888. • Resident #4 was admitted to the facility on 8/27/2023. Significant Change Minimum data set assessment with Assessment Reference Date of 9/15/2023 was completed on 10/2/2023. Assessment was accepted in the state database 10/3/2023 Minimum data set Batch # 1883. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a comprehensive assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14 days timeframes. This audit will be completed by Regional RAI Consultant no later than 11/2/2023. • Effective 11/2/2023 the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the interdisciplinary team members of the residents with assessment reference dates (ARD) for that date as well as any residents with in progress assessments that are due for completion (Minimum data set assessment Z0500 date) on that date. Minimum data set coordinator will review any interdisciplinary team	

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F 636	Continued From page 4	F 636	members that have sections that need completion. This has been added to the daily stand up meeting process. Minimum data set coordinator will send daily stand down report to Administrator reporting that all assessments due for completion that day have been completed. • Regional RAI consultant will audit the current Minimum data set assessments in progress list for comprehensive assessments that are due to be completed (Minimum data set item Z0500 due date) by 11/6/2023. Facility Minimum data set coordinator with assistance of Minimum data set assessment floater staff will complete the identified assessments (in progress comprehensive assessments with Z0500 due date of 11/6/23 or earlier) by 11/6/2023 Systemic Changes By 11/6/2023, the Regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Coordinator that includes the importance of ensuring that each resident receive a comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin	

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F 636	Continued From page 5	F 636	auditing the facility's compliance with comprehensive Minimum Data Set assessments completion time frames as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled "Comprehensive Assessments and Timing Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be completed on 5 residents' completed assessments per audit and will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activities Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 11/6/2023	
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the	F 638		11/6/23

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F 638	Continued From page 6 quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframe as specified in the Resident Assessment Instrument (RAI) manual for 7 of 20 residents reviewed for MDS assessments (Resident #21, Resident #11, Resident #27, Resident #1, Resident #32, Resident #25, Resident #31). Findings included: a. Resident #21 was admitted to the facility on 8/28/20 with diagnoses which included in part chronic kidney disease, failure to thrive and dementia. Review of Resident #21's 7/18/23 quarterly Minimum Data Set assessment revealed the assessment was completed on 8/2/23. b. Resident #11 was admitted to the facility on 8/22/22 with diagnoses which included diabetes. Review of Resident #11's 9/8/23 quarterly MDS revealed the assessment was completed on 9/24/23. c. Resident #27 was admitted to the facility on 1/6/23 end stage renal disease and dialysis. Review of Resident #27's 9/26/23 quarterly MDS revealed the assessment was completed on 10/11/23. d. Resident #1 was admitted to the facility on 9/9/20 with diagnoses which included dementia	F 638	The statements made on this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F638 Quarterly Assessment at Least Every 3 Months Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required 14-day timeframe were completed and submitted to the state database as follows: • Resident #21: Quarterly Minimum data set assessment with Assessment Reference Date of 7/18/2023 was completed on 8/2/2023 and submitted/accepted into state database on 8/3/2023 Minimum data set Batch #1856. • Resident #11: Quarterly Minimum data set assessment with Assessment Reference Date of 9/8/2023 was completed on 9/24/2023 and	

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F 638	Continued From page 7	F 638		

and contractures. Review of Resident #1's 8/20/23 quarterly MDS revealed the assessment was completed on 9/7/23.

e. Resident #32 was admitted to the facility on 3/20/23 with diagnosis which included in part arthritis, diabetes and heart failure. Review of Resident # 32's 8/19/23 quarterly MDS revealed the assessment was completed on 9/7/23.

f. Resident #25 was admitted to the facility on 4/19/23 with diagnosis which included hip fracture. Review of Resident #25's 8/22/23 quarterly MDS revealed the assessment was completed on 9/8/23.

g. Resident #31 was admitted to the facility on 7/21/22 with diagnosis which included in part lumbar disc degeneration, chronic pain and dementia. Review of Resident #31's 9/14/23 quarterly MDS revealed the assessment was completed on 9/29/23.

Interview with the MDS Nurse on 10/19/23 at 10:30 AM revealed she was aware the assessments were late, and they were not completed during the 14-day allotted time from the Assessment Reference Date (ARD). The MDS Nurse said there were corporate nurses that assisted remotely with the completion of assessments. The MDS Nurse stated she was pulled to the floor to work an assignment if needed; was on call every third week of the month for the entire week and if needed she worked the floor or did other tasks as needed; and stated there was a high volume of admissions and discharges.

Interview with the Administrator and the

submitted/accepted into state database on 9/25/2023 Minimum data set Batch #1885.

- Resident #27: Quarterly Minimum data set assessment with Assessment Reference Date of 9/26/2023 was completed on 10/11/2023 and submitted/accepted into state database on 10/12/2023 Minimum data set Batch #1894.
- Resident #1: Quarterly Minimum data set assessment with Assessment Reference Date of 8/20/2023 was completed on 9/7/2023 and submitted/accepted into state database on 9/8/2023 Minimum data set Batch #1875.
- Resident #32: Quarterly Minimum data set assessment with Assessment Reference Date of 8/19/2023 was completed on 9/7/2023 and submitted/accepted into state database on 9/7/2023 Minimum data set Batch #1874.
- Resident #25: Quarterly Minimum data set assessment with Assessment Reference Date of 8/22/2023 was completed on 9/8/2023 and submitted/accepted into state database on 9/11/2023 Minimum data set Batch #1894.
- Resident #31: Quarterly Minimum data set assessment with Assessment Reference Date of 9/14/2023 was completed on 9/29/2023 and submitted/accepted into state database on 10/2/2023 Minimum data set Batch #1888.

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F 638	Continued From page 8 Corporate Nurse Consultant on 10/19/23 at 5:10 PM revealed she was aware of the situation with the MDS assessments not completed within the regulatory timeframe. The Administrator stated the corporate nurses assisted the MDS Nurse with completion of the assessments, but they had other duties also. The Administrator further revealed the MDS Nurse was required to work the floor as a staff nurse and was required to be on call for the nursing department. The Administrator stated the facility was implementing new procedures to check the timeliness of assessments and hoped to see improvement.	F 638	Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a quarterly assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14-day completion timeframes. This audit will be completed by Regional resident assessment instrument consultant no later than 11/6/2023. • Effective 11/2/2023 the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the interdisciplinary team members of the residents with assessment reference dates (ARD) for that date as well as any residents with in progress assessments that are due for completion (Minimum data set assessment Z0500 date) on that date. Minimum data set coordinator will review any interdisciplinary team members that have sections that need completion. This has been added to the daily stand up meeting process. Minimum data set coordinator will send daily stand down report to Administrator reporting that all assessments due for completion that day have been completed. • Regional resident assessment instrument consultant will audit the current Minimum data set assessment in	

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F 638	Continued From page 9	F 638		

progress list for quarterly assessments that are due to be completed (item Z0500 due date) by 11/6/2023. The facility Minimum data set coordinator with the assistance of floater staff will complete these identified quarterly assessment by 11/6/2023

By 11/1/2023 the regional resident assessment instrument consultant will conduct education/training with the facility Minimum Data Set Nurse on the importance of scheduling and completing a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education will emphasize that all residents must have no more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus will be placed on the importance of ensuring that all Minimum Data Set assessments be completed in the required time frames, as well as encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual.

Monitoring
The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements;

The Administrator and/or designee will review 5 random residents who have recently completed Quarterly minimum

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F 638	Continued From page 10	F 638	data set assessment to validate whether or not most recent Minimum data set quarterly assessment was completed (Z0500 date) within the 14 day required timeframe (date of Z0500 assessment completion date). This will be completed using the Quality Assurance tool entitled "Quarterly Completion of Minimum Data Set Assessments" Audit tool. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activities Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 11/6/2023	
F 641 SS=B	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 observation, staff interviews, and record review the facility failed to accurately code Minimum Data Set (MDS) assessments to reflect	F 641	The statements made on this plan of correction are not an admission to and does not constitute an agreement with the	11/6/23

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F 641	Continued From page 11 ostomy status and use of assistive devices for ambulation, (Resident #47); and failed to accurately assess a resident's cognition and participation in the assessment and goal setting, (Resident #38), for 2 of 23 residents reviewed for MDS assessments. 1. a. Resident #47 was admitted to the facility on 8/19/21 with diagnoses that included, in part: Type 2 Diabetes Mellitus, Stage 3 chronic kidney disease, right knee pain, frequent bowel and bladder incontinence, and a history of falls. An observation of Resident #47 was made on 10/16/23 at 2:30 PM. She was sitting in her wheelchair self-propelling in the hallway. An additional observation was made on 10/18/23 in the afternoon when Resident #47 attended the Resident Council meeting using a wheelchair. Review of an annual MDS assessment completed on 09/28/23 documented Resident #47 did not use any assistive devices for ambulation. An interview with the MDS Nurse on 10/19/23 at 10:30 AM revealed Resident #47 had used a wheelchair for ambulation during the assessment period in September 2023. She noted the assessment had been completed by a corporate MDS nurse remotely. She reported it had been clearly documented in the electronic record that Resident #47 used a wheelchair for ambulation during the assessment period. She concluded she did not know why the corporate MDS Nurse did not document Resident #47 used a wheelchair for ambulation and that she had modified the assessment to accurately document how Resident #47 ambulated.	F 641	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-641 Accuracy of Assessments Corrective actions Resident #47 Minimum data set annual assessment with Assessment Reference date of 9/28/2023 reviewed and resident does not have wheelchair use coded on the Minimum Data Set. Minimum data set assessment with Assessment reference date of 9/28/2023 was modified and corrected by the facility Minimum Data Set Nurse on 10/18/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment. Resident #47 Minimum data set assessment with Assessment reference date of 6/28/2023 was reviewed and findings revealed resident did not have an ostomy during the assessment reference date look back timeframe of the assessment. Minimum data set assessment with assessment reference date of 6/28/2023 was modified and corrected by the facility Minimum Data Set Nurse on 10/18/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment.	

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F 641	Continued From page 12 b. The bowel and bladder section of the quarterly MDS assessment dated 06/28/23 for Resident #47 documented she had an ostomy. Review of all progress notes in June 2023 revealed Resident #47 did not have an ostomy. An interview with the MDS Nurse on 10/19/23 at 10:30 AM revealed Resident #47 never had an ostomy. She reported the assessment had been completed by a corporate MDS Nurse remotely. She stated when she reviewed the data, she discovered the task section in the computer system that is completed by Nurse Aides was completed incorrectly documenting that the resident had an ostomy. This information auto populated into the assessment dated 06/28/23. She concluded the nurse who completed the assessment should have reviewed the information that auto populated and changed the assessment to reflect Resident #47 did not have an ostomy. She stated she modified the assessment to accurately document Resident #47 did not have an ostomy. An interview was conducted with the Administrator on 10/19/23 at 4:30 PM. The Administrator stated she expected MDS assessments to be accurate. 2) Resident #38 was admitted to the facility on 12/31/21. Diagnoses included, in part, dementia with anxiety. The MDS quarterly assessment dated 09/13/23 revealed section C for cognition was coded as "not assessed" and section Q for participation in assessment and goal setting was coded as "not assessed."	F 641	Resident #38 Minimum data set quarterly assessment with Assessment Reference Date of 9/13/2023 coded “not assessed” for section C cognition and section Q participation and goal setting as the interview was not completed with resident. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents who use wheelchair mobility devices and current residents who use appliances for urinary/bowel elimination will be completed in order to identify if the following questions were coded accurately in the section of G0600 Mobility devices (section GG0120 Mobility Devices for identified assessments with Assessment Reference Date 10/1/2023 or later) and section H0100 Appliances on the Minimum data set assessment: • G0600C- wheelchair (manual or electric)/ section GG0120 Mobility Devices for Assessment Reference Date 10/1/2023 or later • H0100C- Ostomy (including urostomy, ileostomy, and colostomy) • This audit will be completed by Administrator no later than 11/6/2023. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data	

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F 641	Continued From page 13 An interview was conducted with the Social Worker (SW) on 10/19/23 at 10:45 AM. The SW revealed she was usually responsible for completing section C and section Q of the MDS assessments, but she was out of facility at the time the assessment was due. She stated the Activities Director would have been responsible for completing the assessment for any MDS portions the SW was responsible for if she was unavailable. An interview with the Activities Director on 10/19/23 at 2:00 PM revealed on the quarterly assessment dated 09/13/23, she was responsible for completing Resident #38's assessment in section C and Q. The Activities Director stated she could not remember why she did not complete the assessment and added "it was an oversite." An interview was conducted with the Administrator on 10/19/23 at 4:55 PM. The Administrator stated her expectation of the staff was to complete the MDS assessments accurately and in their entirety to reflect the current care of the residents.	F 641	Set Coordinator. Any necessary Minimum data set corrections will be completed no later than 11/6/2023. Systemic Changes By 11/6/2023, the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse that includes the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Special emphasis will be placed on the following areas of the Minimum Data Set assessment: - GG0120C wheelchair mobility devices the resident normally uses for locomotion (in room and in facility) (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs. -H0100C, ostomy (including urostomy, ileostomy, and colostomy) By 11/6/2023, the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse, Social service coordinator, and activity director. In-service training includes the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Special emphasis will be placed on the following areas of the Minimum Data Set assessment: -Section C0100 Brief Interview for Mental	

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F 641	Continued From page 14	F 641	Status Interview (BIMS interview) -Section Q0110 Participation in Assessment and Goal Setting - Section Q0310 Resident's Overall Goal The Minimum Data Set needs to be thoroughly reviewed for accuracy prior to closing and locking the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for accuracy in coding on the Minimum data set assessment for C0100 BIMs interview, Q0110 Participation in assessment and goal setting, and Q0310 Resident's overall goal. This audit will be done weekly x 4 weeks and then monthly x 2 months using the audit tool titled "Accurate Coding of MDS Audit Tool". Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager	

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F 641	Continued From page 15	F 641	and the Activities Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 11/6/2023	
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 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, manufacturer's recommendations review, and staff interviews,	F 761	The statements made on this plan of correction are not an admission to and do	11/6/23

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F 761	Continued From page 16 the facility failed to 1) securely store medication on an unattended medication cart for 1 of 2 (200 hall) medication carts observed for medication pass and 2) failed to dispose of 2 expired inhalers on the 300-hall medication cart for 1 of 2 medication carts reviewed for medication storage. Findings included: 1) A continuous observation on 10/18/23 from 9:05 AM to 9:10 AM revealed a white paper medication cup with a white capsule on top of the 200-hall medication cart unattended in an area where residents and staff could access. The medication cart was not within direct observation of a nurse. Housekeeper #1 and Nursing Assistant (NA) #1 passed the unattended medication cart in the hallway several times at the time the medication was observed on top of the medication cart. There were cognitively impaired residents as well as visitors in the vicinity of the medication cart. At 9:10 AM Nurse #1 came out of a resident room down the hallway and returned to the unattended 200 hall medication cart. Nurse #1 stated she was assigned to the 200-hall medication cart. Nurse #1 observed the medication in the white paper medicine cup, stated it was medication for a resident and she must not have seen it when she went to give the other medications. The medication was identified as gabapentin, a medication used to treat seizures and nerve pain. During an interview on 10/18/23 at 9:01 AM Nurse #1 revealed the medication should not have been left unattended on top of the medication cart and she must not have seen it when she administered medications to one of the residents.	F 761	not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F 761 The facility failed to follow the manufacturer's recommendations and review to 1) securely store medication on an unattended medication cart for 1 of 2 (200 hall) medication carts observed for medication pass and 2) failed to dispose of 2 expired inhalers on the 300-hall medication cart for 1 of 2 medication carts reviewed for medication storage. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 10/18/23 Nurse #1 (200 hall medication cart) disposed of the medication identified as gabapentin. On 10/18/23 Nurse #2 (300 hall medication cart) disposed of Resident #19's Stiolto Aero Respimat inhaler per manufacturer's recommendations. On 10/18/23 Nurse #2 (300 hall medication cart) disposed of Resident #16's Trelegy Ellipta 100 microgram inhaler per manufacturer's recommendations. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 10/30/23 the Director of Nurses / Unit	

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F 761	Continued From page 17 An interview was conducted on 10/19/23 at 5:10 PM with the Corporate Nurse Consultant, in the presence of the Administrator. The Corporate Nurse Consultant further stated Nurse #1 made a mistake and should not have left medication unattended on top of the medication cart. 2). An observation of the 300-hall medication cart and interview with Nurse #2, the nurse assigned, on 10/18/23 at 10:53 AM revealed the following: a. The manufacturer's recommendations indicated the Stiolto Aero Respimat inhaler expired 90 days after assembly of the device (cartridge into the dispensing unit). An observation of Resident #19's Stiolto Aero Respimat inhaler had a pharmacy label which indicated the medication was delivered on 7/3/23 and had an expiration date of 10/1/23. An interview on 10/18/23 at 10:53 AM with Nurse #2 revealed the label on Resident #19's inhaler indicated the medication was expired and it should have been discarded. Nurse #2 stated she had administered the Stiolto inhaler to Resident #19 that morning and did not recall checking the expiration day prior to administration. b. The manufacturer's recommendations indicated the Trelegy Ellipta inhaler expired 6 weeks after it was opened. Resident #16's Trelegy Ellipta 100 microgram inhaler had a label on the inhaler which indicated the date opened was 8/21/23 and to discard the medication 6 weeks after it was opened. The	F 761	Managers audited all medication carts to ensure that all medications were properly stored when medication cart unattended. The results included: no concerns identified. On 10/30/2023 the Director of Nursing / Unit Manager implemented corrective action to include: ongoing audits to ensure that all medications are properly stored when medication cart is unattended at least weekly x2 and monthly x3. On 10/30/23 the Director of Nurses/Unit managers audited all medication carts to ensure that no expired medication remain on carts by referencing the manufacturer recommendations. The results included: no concerns identified. On 10/30/2023 the Director of Nursing / Unit managers implemented corrective action to include: ongoing audits to ensure that no expired medication remain on carts by referencing the manufacturer recommendations at least weekly x2 and monthly x3. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 10/30/2023 the Director of Nurses began education of all Full Time, Part Time, as needed nurses, medication aides and agency nurses on facility policy related to medication safety that included safely securing and storing medications, labeling of the date medication opened and checking expiration dates on medications to assure no expired medications are administered. Education will be completed by 10/31/2023. This information has been integrated into	

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F 761	Continued From page 18 printed label from the pharmacy, on the bag indicated an expiration date of 10/2/23. An interview on 10/18/23 at 10:55 AM with Nurse #2 revealed the labels on Resident #19 and Resident #16's inhalers indicated the medications were expired and should have been discarded. Nurse #2 stated all nurses were expected to check the expiration dates when administering medications. Nurse #2 explained she thought the medication carts were checked by someone regularly, but she was not sure who did this or when. Nurse #2 further indicated she had administered the inhalers to Resident #19 and Resident #16 that morning and had not noticed that the medications were expired. An interview on 10/19/23 at 5:00 PM with the Director of Nursing (DON) revealed expired medications should be discarded and medications should be securely stored on the medication carts. An interview was conducted on 10/19/23 at 5:10 PM with the Administrator and the Corporate Nurse Consultant. The Administrator revealed the facility was working to ensure there were no expired medications on the medication cart. The Corporate Nurse Consultant stated it was a human error that the facility did not discard the expired medications from the medication cart, and it was a problem that required constant staff reminders and auditing.	F 761	the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/1/23. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee for F761 Adequate Label/Store Drugs and Biologicals to assess that all medications are safely and appropriately stored, that no expired medications are on the medication cart. Audits of medication carts to ensure all medications are stored properly and secured when cart not in attendance and all medications stored and disposed of per manufacturers' guidelines will be completed weekly x 2 and monthly x 3 or until resolved for compliance with this process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set	

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F 761	Continued From page 19	F 761	Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activities Director. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 11/6/2023	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		11/6/23

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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.

§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;

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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 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;

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F 867	Continued From page 22 (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 and staff interviews the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint investigation survey completed on 6/24/22 and the recertification survey completed on 3/12/21. This was for three repeat deficiencies originally cited in the areas of comprehensive assessments (F636), quarterly assessments (F638) and labeling and storing of medication (F761) recited on the current recertification and complaint investigation survey of 10/19/23. The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F636: Based on record review and staff interviews the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 3 of 20 residents reviewed for MDS assessments (Resident #47, Resident #46, Resident #4). During the recertification and complaint investigation survey of 6/24/22, the facility failed	F 867	The statements made on this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint investigation survey completed on 6/24/22 and the recertification survey completed on 3/12/21. This was for three repeat deficiencies originally cited in the areas of comprehensive assessments and timing (F636), quarterly assessments at least every 3 months, (F638) and label/store of drugs and biologics (F761) recited on the current recertification and complaint investigation survey of 10/19/23. The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program.	

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F 867	Continued From page 23 to 1) complete Minimum Data Set (MDS) admission assessments within the required timeframe for 2 of 9 residents 2) failed to complete a discharge with return anticipated assessment within the required timeframe for 1 of 9 residents and 3) failed to complete a 14-day MDS assessment within the required timeframe for 1 of 9 residents reviewed for Resident Assessments. Interview with the Administrator on 10/19/23 at 5:10 PM revealed the QAA program for MDS assessments did not work due to it not being continued long enough. The Administrator further revealed there were changes in the facility that have caused the measures implemented to not be sustained. The Administrator indicated closer monitoring and evaluation of the interventions implemented was necessary to sustain the QAA program. F638: Based on record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframe as specified in the Resident Assessment Instrument (RAI) manual for 7 of 20 residents reviewed for MDS assessments (Resident #21, Resident #11, Resident #27, Resident #1, Resident #32, Resident #25, Resident #31). During the recertification and complaint investigation survey completed on 6/24/22, the facility failed to complete quarterly MDS assessments within 14-calendar days of the Assessment Reference Date (ARD, the last day of the look-back period) for 5 of 9 residents reviewed for resident assessments.	F 867	1.Corrective action for resident(s) affected by the alleged deficient practice: F636: Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required 14 day timeframe were completed as follows: • Resident #47 was admitted to the facility on 8/19/2021. Annual Minimum data set assessment with Assessment Reference Date of 9/28/2023 was completed on 10/13/2023. Assessment was accepted in the state database 10/19/2023 Minimum data set Batch #1896. • Resident #46 was admitted to the facility on 3/4/2021. Significant Change Minimum data set assessment with Assessment Reference Date of 9/14/2023 was completed on 9/29/2023. Assessment was accepted in the state database 10/2/2023 Minimum data set batch #1888. • Resident #4 was admitted to the facility on 8/27/2023. Significant Change Minimum data set assessment with Assessment Reference Date of 9/15/2023 was completed on 10/2/2023. Assessment was accepted in the state database 10/3/2023 Minimum data set Batch # 1883. F638: Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required	

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F 867	Continued From page 24 Interview with the Administrator on 10/19/23 at 5:10 PM revealed the QAA program for MDS assessments did not work due to changes in the facility that caused the measures implemented to not be sustained. The Administrator further revealed that the facility needed to improve systems that were implemented and investigate why the previous program did not work. F761 Based on observations and staff interviews, the facility failed to 1) securely store medication on an unattended medication cart for 1 of 2 (200 hall) medication carts observed for medication pass and 2) failed to dispose of 2 expired inhalers on the 300-hall medication cart for 1 of 2 medication carts reviewed for medication storage. During the recertification survey of 3/12/21, the facility failed to keep unattended treatment medications (creams and ointments) secured in a locked treatment cart for 1 of 1 treatment carts observed. During the recertification and complaint investigation survey of 6/24/22, the facility 1) failed to remove expired medications from 2 of 3 medication carts (100 hall and 200 hall medication carts), 2) failed to record an opened date for a narcotic located in the locked box in 1 of 1 medication refrigerators and 3) failed to secure medications stored on top of 1 of 3 unattended medication carts. (Medication storage cart 300 Hall) Interview with the Administrator on 10/19/23 at 5:10 PM revealed the QAA program should have investigated the deficient practice related to labeling and storage of medication more closely and the interventions implemented should have	F 867	14-day timeframe were completed and submitted to the state database as follows: • Resident #21: Quarterly Minimum data set assessment with Assessment Reference Date of 7/18/2023 was completed on 8/2/2023 and submitted/accepted into state database on 8/3/2023 Minimum data set Batch #1856. • Resident #11: Quarterly Minimum data set assessment with Assessment Reference Date of 9/8/2023 was completed on 9/24/2023 and submitted/accepted into state database on 9/25/2023 Minimum data set Batch #1885. • Resident #27: Quarterly Minimum data set assessment with Assessment Reference Date of 9/26/2023 was completed on 10/11/2023 and submitted/accepted into state database on 10/12/2023 Minimum data set Batch #1894. • Resident #1: Quarterly Minimum data set assessment with Assessment Reference Date of 8/20/2023 was completed on 9/7/2023 and submitted/accepted into state database on 9/8/2023 Minimum data set Batch #1875. • Resident #32: Quarterly Minimum data set assessment with Assessment Reference Date of 8/19/2023 was completed on 9/7/2023 and submitted/accepted into state database on 9/7/2023 Minimum data set Batch #1874. • Resident #25: Quarterly Minimum	

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F 867	Continued From page 25 been revised as needed to be successful at maintaining the program. The Administrator further stated ongoing monitoring and education was required to ensure that expired or unsecured medications were not observed on the medication carts.	F 867	data set assessment with Assessment Reference Date of 8/22/2023 was completed on 9/8/2023 and submitted/accepted into state database on 9/11/2023 Minimum data set Batch #1894. • Resident #31: Quarterly Minimum data set assessment with Assessment Reference Date of 9/14/2023 was completed on 9/29/2023 and submitted/accepted into state database on 10/2/2023 Minimum data set Batch #1888. F671: Corrective Action The facility failed to follow the manufacturer's recommendations and review to 1) securely store medication on an unattended medication cart for 1 of 2 (200 hall) medication carts observed for medication pass and 2) failed to dispose of 2 expired inhalers on the 300-hall medication cart for 1 of 2 medication carts reviewed for medication storage. On 10/18/23 Nurse #1 (200 hall medication cart) disposed of the medication identified as gabapentin. On 10/18/23 Nurse #2 (300 hall medication cart) disposed of Resident #19's Stiolto Aero Respimat inhaler per manufacturer's recommendations. On 10/18/23 Nurse #2 (300 hall medication cart) disposed of Resident #16's Trelegy Ellipta 100 microgram inhaler per manufacturer's recommendations.	

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2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
All residents have the potential to be affected by the alleged deficient practice. F636:

All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a comprehensive assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14 days timeframes. This audit will be completed by Regional RAI Consultant no later than 11/2/2023.

• Effective 11/2/2023 the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the interdisciplinary team members of the residents with assessment reference dates (ARD) for that date as well as any residents with in progress assessments that are due for completion (Minimum data set assessment Z0500 date) on that date. Minimum data set coordinator will review any interdisciplinary team members that have sections that need completion. This has been added to the daily stand up meeting process. Minimum data set coordinator will send daily stand down report to Administrator reporting that all assessments due for completion that

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F 867	Continued From page 27	F 867	day have been completed. • Regional resident assessment instrument consultant will audit the current Minimum data set assessments in progress list for comprehensive assessments that are due to be completed (Minimum data set item Z0500 due date) by 11/6/2023. Facility Minimum data set coordinator with assistance of Minimum data set assessment floater staff will complete the identified assessments (in progress comprehensive assessments with Z0500 due date of 11/6/23 or earlier) by 11/6/2023. F638: All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a quarterly assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14-day completion timeframes. This audit will be completed by Regional resident assessment consultant no later than 11/6/2023 • Effective 11/2/2023 the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the interdisciplinary team members of the residents with assessment reference dates (ARD) for that date as well as any residents with in progress assessments that are due for completion (Minimum	

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data set assessment Z0500 date) on that date. Minimum data set coordinator will review any interdisciplinary team members that have sections that need completion. This has been added to the daily stand up meeting process. Minimum data set coordinator will send daily stand down report to Administrator reporting that all assessments due for completion that day have been completed.

• Regional resident assessment instrument consultant will audit the current Minimum data set assessment in progress list for quarterly assessments that are due to be completed (item Z0500 due date) by 11/6/2023. The facility Minimum data set coordinator with the assistance of floater staff will complete these identified quarterly assessments by 11/6/2023.

By 11/1/2023 the regional resident assessment instrument consultant will conduct education/training with the facility Minimum Data Set Nurse on the importance of scheduling and completing a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education will emphasize that all residents must have no more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus will be placed on the importance of ensuring that all Minimum Data Set assessments be completed in the required time frames, as well as encoded and transmitted within

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the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual.

F641:

All residents have the potential to be affected by the alleged deficient practice. A 100% audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents who use wheelchair mobility devices and current residents who use appliances for urinary/bowel elimination will be completed in order to identify if the following questions were coded accurately in the section of G0600 Mobility devices (section GG0120 Mobility Devices for identified assessments with Assessment Reference Date 10/1/2023 or later) and section H0100 Appliances on the Minimum data set assessment:

- G0600C- wheelchair (manual or electric)/ section GG0120 Mobility Devices for Assessment Reference Date 10/1/2023 or later
- H0100C- Ostomy (including urostomy, ileostomy, and colostomy)
-

This audit will be completed by Administrator no later than 11/6/2023. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator. Any necessary Minimum data set corrections will be completed no later than 11/6/2023.

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F 867	Continued From page 30	F 867	F761: On 10/30/23 the Director of Nurses / Unit Managers audited all medication carts to ensure that all medications were properly stored when medication cart unattended. The results included: no concerns identified. On 10/30/2023 the Director of Nursing / Unit Manager implemented corrective action to include: ongoing audits to ensure that all medications are properly stored when medication cart is unattended at least weekly x2 and monthly x3. On 10/30/23 the Director of Nurses/Unit managers audited all medication carts to ensure that no expired medication remain on carts by referencing the manufacturer recommendations. The results included: no concerns identified. On 10/30/2023 the Director of Nursing / Unit managers implemented corrective action to include: ongoing audits to ensure that no expired medication remain on carts by referencing the manufacturer recommendations at least weekly x2 and monthly x3. The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 10/30/2023 to review the deficiencies from the October 16, 2023 to October 19, 2023 annual recertification survey, CI survey, and reviewed the citations to include root cause analysis to develop corrective plan of action to prevent repetition of deficient practice. Root Cause Analysis: Facility Administrator and Director of nursing	

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F 867	Continued From page 31	F 867	failed to continue audits and sustain appropriate systemic changes when areas of improvement were identified. Facility Administrator and Director of nursing required further education on Quality Assurance Performance Improvement processes. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 10/31/2023, the Nurse Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the Quality Assurance Performance Improvement Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. On 11/1/2023 the administrator completed in-servicing with the Quality Assurance Performance Improvement team members that include the Administrator, Director of Nurses, LPN Support Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Social Service Coordinator, BOM, Admissions and Marketing Director, Transportation Aide/Central Supply, Nurse Secretary/Housekeeping Supervisor, and Maintenance Director on the appropriate functioning of the Quality Assurance Performance Improvement Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the	

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F 867	Continued From page 32	F 867	Quality Assurance Performance Improvement Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/5/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the comprehensive assessments and timing, quarterly assessments at least every 3 months, and labeling/storage of drugs and biologics. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager	

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F 867	Continued From page 33	F 867	and the Activities Director. Date of Compliance: 11/6/2023	